Family Treatment Drug Court Evaluation

FINAL REPORT

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EXECUTIVE SUMMARY

This report presents the findings of a national evaluation of Family Treatment Drug Courts (FTDCs) conducted by NPC Research and funded by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. Family Treatment Drug Courts are specialized courts designed to work with substance-abusing parents involved with the child welfare system. The national evaluation examined whether court, child welfare, and treatment outcomes differed for families served through FTDCs as compared to families who received traditional child welfare services. Furthermore, the evaluation explored not only *whether* drug courts work, but also *how* and for *whom* they work.

The study focused on four FTDCs located in California (San Diego and Santa Clara Counties), Nevada (Washoe County), and New York (Suffolk County). These four sites represented differing FTDC models: San Diego County employed a model in which all substance abusing parents were provided intensive recovery management services through the Substance Abuse Recovery Management System (SARMS), which was the first Tier of a system model. Those clients that were noncompliant with SARMS were offered the second Tier of the system, which was the Dependency Drug Court. Approximately 10% of all Tier 1 cases go on to enter Tier II. Santa Clara and Washoe Counties had a more traditional, stand-alone drug court serving primarily parents whose children had been removed from their care; and Suffolk County had a stand-alone drug court that accepted parents with neglect allegations only (and as a result, many

children at this site were not removed from their homes).

The study included the collection of administrative data from court, child welfare, and treatment data sources on a total of 802 FTDC and 1,167 comparison cases. While some study cases consisted of two-parent families, and a small handful of cases consisted of father-only cases, for the purposes of this report we have focused on outcomes for mothers and their families (739 FTDC cases and 1,120 comparison cases). The report also includes parent interview data from a subset of 136 FTDC mothers.

Do Drug Courts Work?

The outcomes included in this evaluation can be grouped into three categories: treatment outcomes, child welfare outcomes, and court outcomes. We present the study findings for each of these categories of outcomes below.

TREATMENT OUTCOMES

One of the primary goals of the FTDC is to support families to access, remain in, and successfully complete substance abuse treatment services. Treatment outcomes examined as part of this study included the likelihood of treatment entry, the length of time between petition and

treatment entry, the number of days spent in treatment during the case, and the likelihood of treatment completion. Results showed the following:

- **Treatment Entry**: At two of the four study sites (Santa Clara and Suffolk), FTDC mothers were significantly more likely to enter treatment than the comparison mothers, and when effects were pooled across the four sites, FTDC mothers overall were significantly more likely to enter treatment than comparison mothers. However, the pooled effect size was relatively small (d=0.2), indicating that on average, these four FTDCs had a modest influence on treatment entry.

- **Time to Treatment**: At one of the four study sites (Suffolk), FTDC mothers entered treatment significantly faster after the initial child welfare petition than did comparison mothers, and when effects were pooled across all four sites, FTDC mothers entered treatment significantly faster than comparison mothers. Again, however, the pooled effect size was relatively small (d=0.2), no doubt due to the lack of significant impacts on time to treatment entry at three of the four sites.

- **Length of Stay in Treatment**: At three of the four study sites (Santa Clara, Suffolk, and Washoe), FTDC mothers spent significantly more days in substance abuse treatment than did comparison mothers. In these sites, FTDC mothers spent ***almost twice as long*** in treatment than did comparison mothers. Not surprisingly, the pooled effect size across the four study sites was significant and moderate in size (d=0.4), indicating that FTDC appears to have a relatively strong effect on time spent in treatment.

- **Treatment Completion**: Similarly, at these same three study sites, FTDC mothers were significantly more likely to complete treatment than comparison mothers. This result held true both for all mothers in the samples as well as for the subset of mothers who entered treatment. Again, the magnitude of these differences were both statistically and practically significant: Treatment completion rates in three of the study sites were ***almost double*** among FTDC mothers. When the effects were pooled across the four sites, FTDC mothers were significantly more likely to complete treatment than comparison mothers. However, the overall effect sizes were relatively small (d=0.2 for all mothers and d=0.3 for just those mothers who entered treatment), again related to the lack of impact in one of the study sites.

FTDC parents were more likely to enter treatment, entered treatment more quickly, stayed in treatment longer, and were more likely to complete treatment than comparison parents.

CHILD WELFARE OUTCOMES

Ultimately, FTDCs strive to support successful treatment and recovery for parents so that they can be reunified with their children (if appropriate). The study examined a number of outcomes related to the child welfare case experience, the case resolution, and child welfare recidivism.

Child Welfare Case Experience

We measured several aspects of the child welfare case experience, including the number of services received by children and the number and type of living situations for children.

- **Services to Children.** At one study site (San Diego), FTDC children received significantly more services during their case than comparison children, however, pooling effects across the four study sites resulted in no significant differences in the number of services received by FTDC and comparison children.
- **Placement Changes.** At one of the four study sites (Santa Clara), children of FTDC mothers experienced significantly *more* living situation changes, even after controlling for length of case. While there were no significant differences on this variable at the remaining three sites, when the effects were pooled across the four sites, FTDC children did have significantly more living situation changes than comparison children. Despite statistical significance, the pooled effect was very small (d=0.1), no doubt due to the isolation of this effect at one program site only.
- **Days in Parental Care.** Because children tended to have multiple placements during their cases, they often spent portions of their cases in parental care. At two of the four study sites (Santa Clara and Washoe), FTDC children spent significantly more days (and a higher percentage of their cases) in parental care than did comparison children; similarly, when the effects across the four sites were pooled, FTDC children spent a greater percentage of the case and more absolute days with their mothers than comparison children. These pooled effect sizes (d=0.3 for number of days spent with mothers and d=0.2 for proportion of the case spent with mothers) indicate that across the four sites, there was a modest effect on time spent in parental care.
- **Time in Out of Home Placement.** Not surprisingly, at these same two sites, FTDC children spent significantly fewer days (and a smaller percentage of their cases) in any out-of-home placements (kin or non-kin). Again, the pooled effect was somewhat small, reflecting the lack of impact at two of the sites (d=0.2).
- **Kinship Care.** There were no significant differences at any of the sites (or across the four sites when effect sizes were pooled) for the number of days or percent of case that children spent in kinship placements.

Children of FTDC mothers spent fewer days in out-of-home placements and were more than twice as likely to be reunified with their parents, compared to non-FTDC children.

Permanency Outcomes

The study included several measures reflecting the child's permanency outcomes, including the length of time from petition to permanent placement as well as an examination of the types of permanent placement.

- **Time to Permanency**. At one study site (Santa Clara) it took significantly *longer* for children of FTDC mothers to reach permanent placement than children of comparison mothers. The remaining three sites exhibited the same trend, though the results did not reach significance. The pooled effect size, not surprisingly was small (d=0.2).
- **Time to Reunification**. FTDC cases that resulted in reunifications took significantly longer to reach that permanent placement than did cases that resulted in another permanency decision. However, cases that resulted in a termination of parental rights did not

take significantly longer in FTDC cases than in comparison cases. This suggests that FTDCs are moving quickly to find permanent solutions for children for whom reunification is not an option, and are taking more time to be sure that mothers who will reunify are ready to do so.

- **Rates of Reunification**. At three of the four study sites (San Diego, Santa Clara, and Washoe), children of FTDC mothers were significantly more likely to be reunified than children of comparison mothers, and at two sites (Santa Clara and Washoe), FTDC children were significantly less likely to have terminations of parental rights. In these two sites, children in the FTDC group were ***more than twice*** as likely to be reunified than children in the comparison group. Not surprisingly, when effects were pooled across the four sites, there was a small effect, on average, of FTDC on permanency decisions (d=0.3).

FTDC participation contributed to the likelihood of reunification above and beyond its effect on treatment.

Child Welfare Recidivism Outcomes

We investigated child welfare recidivism for the mothers involved in the study as well as for the children. Overall, recidivism rates for mothers and children across all sites and groups were low, with only one significant difference at one site between FTDC and comparison samples. This is likely due, at least in part, to the short study window; we collected two years of data (from date of original petition) for each family, and therefore there simply was not adequate time to capture recidivism.

Furthermore, interpreting recidivism rates can be complicated by the fact that FTDC mothers may be under closer scrutiny than comparison group mothers, and therefore may be more likely to come to the attention of child welfare workers again, resulting in higher, not lower recidivism rates. However, with the exception of one recidivism measure for one site (in Suffolk, FTDC mothers had significantly more new CPS petitions than comparison mothers), we found no significant differences between the groups.

COURT OUTCOMES

The study examined parent compliance with case plans as well as the length of court cases.

- **Case Compliance**. At three of the four sites (San Diego, Santa Clara, and Washoe), FTDC mothers were significantly less likely than comparison mothers to have indications of noncompliance in their court record. When effects were pooled across the four sites, FTDC clients were significantly less likely than comparison mothers to have indications of noncompliance, though the effect size was small (d=0.3).
- **Length of Court Cases**. At all sites, FTDC cases were significantly longer than comparison cases, and the pooled effect size was moderate (d=0.6). However, at the time of data collection 41% of FTDC cases and 37% of comparison cases were still open; thus, it is likely that the length of cases reported here is an underestimate of their actual length, and therefore, this result should be interpreted with caution.

What Makes Drug Courts Work?

In addition to measuring the differences in outcomes between FTDC and comparison cases, the evaluation collected a variety of information (through administrative record review and through parent interviews) that allowed for an examination of *how* and *for whom* drug courts work. The analysis of these data was aimed at investigating (1) the effects of FTDC experiences on outcomes, (2) the effects of treatment experiences on outcomes, (3) the effects of parent characteristics on FTDC experiences and outcomes and (4) whether FTDC participation, over and above its contribution to treatment outcomes, had a unique, "value added" contribution to reunification. These findings are summarized below.

- Mothers who spent more time in FTDC, had more FTDC appearances, and who graduated from FTDC were more likely to have longer treatment stays, complete treatment, and reunify with their children.
- The more quickly mothers entered treatment and the longer they stayed in treatment, the more likely they were to complete treatment, but only treatment completion was directly related to the likelihood of reunification. Mothers who completed treatment were significantly more likely to be reunified with their children.
- Few parent characteristics were related to FTDC experiences, and similarly, few parent characteristics were related to treatment or reunification outcomes.
- Mothers who participated in FTDC experienced higher rates of treatment completion, which in turn was associated with higher rates of reunification. However, participating in the FTDC also contributed to the likelihood of reunification *above and beyond* its effect on treatment. Data from qualitative interviews conducted as part of this study begin to paint a picture of the unique features of FTDCs that could contribute to this effect, including the relationship established between parents and judges that fosters emotional support, accountability, and collaboration.

Discussion

Results from this study show evidence for the effectiveness of the FTDC program model on treatment and child welfare outcomes, especially in the two study sites (Santa Clara and Washoe) that adopted a more "traditional" FTDC model. This model included a focus on parents whose children have been removed from their care, and involved frequent court appearances, timely access to quality treatment services, and a success in supporting parents as they work toward recovery. At these two sites, FTDC participation was associated with statistically and practically significant results:

- 55%-60% increases in the length of stay in treatment services for participants;
- 40%-54% increases in the rates of treatment completion for participants;
- 14-36% reductions in the number of days spent in out-of-home placements; and
- 42%-50% increases in the percentage of children reunified with their parents.

Results in the other two sites were more mixed. In Suffolk County, treatment outcomes were positive, but placement outcomes did not show the same pattern of positive results. This may be due to several conditions unique to that site, includ-

ing the fact that many children were never placed outside the home and the fact that cases at that site were longer than cases at the other study sites (indeed, 57% of Suffolk's cases had not closed at the time of our data collection), which meant that we were unable to gather case outcome information for many cases.

Results were least favorable for San Diego County. Indeed, the overall level of outcomes, and most especially treatment outcomes, for the San Diego group look more similar to the comparison groups across the four sites than to the FTDC treatment group outcomes at other sites. There are several possible reasons for this. First, there were significant implementation issues during the study period, which may have influenced the success of the program, including the retirement of the founding judge (who was followed by a succession of other judges) and funding cuts that led to reduced services and waiting lists. It may also be that the model does not represent the best approach, especially for higher risk parents. The San Diego model calls for all parents with substance abuse issues to participate in the first Tier of less-intensive services for a period of time, and those parents who are noncompliant or unsuccessful are then referred to the second Tier. Given research that suggests that parents' entry into the child welfare system may represent an immediate window of opportunity for intervention, these delays, and indeed, repeated failures, may eventually undermine parents' motivation and lead to less successful outcomes.

Results from this study also begin to provide some information about what is important to successful FTDC programs. Parents who were most successful varied in terms of demographic and case characteristics, suggesting that the model is effective for a broad range of parents. Not surprisingly, successful parents who graduated from FTDC and who were reunified with their children were those who had timely access to treatment services and who were able to remain in, and complete, treatment. Furthermore, findings from this study indicate that while FTDCs' influence on treatment experiences is significant and an important factor in parents' success, FTDC participation itself, apart from its influence on treatment experiences, also is a contributor to parents' success. That is, parents who participated in FTDCs who had positive treatment experiences were more likely to be reunified with their children than comparison group parents with similar treatment experiences. Further research is necessary to unpack this "value added" of FTDCs.

It is also clear that success for FTDC parents takes time — most parents remained in the drug court for about a year, and thus tended to have longer court cases and took longer to reach permanent placement. Given the timelines mandated by the Adoption and Safe Families Act, and the fact that the proliferation of FTDCs has occurred in large part in reaction to ASFA, the fact that this study found no indication that FTDC cases reach permanency faster raises questions about whether reduced time to permanency is a realistic goal for parents in the FTDC program. However, it should also be noted that permanent placements were made, on average, in less than one year in all sites, well within the ASFA timeline.

Finally, it is worth noting that the study did not find significant differences in child welfare recidivism between FTDC and comparison cases. This could be due, in large part, to the 2-year data collection window for this study. Further research is needed that that can track recidivism at both the child and parent level.

CHAPTER 1: INTRODUCTION

This report presents the findings of a national evaluation of Family Treatment Drug Courts (FTDCs) conducted by NPC Research and funded by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. Family Treatment Drug Courts are specialized courts designed to work with substance-abusing parents involved with the child welfare system. The national evaluation, which focused on four FTDCs located in California, Nevada, and New York, examined whether court, child welfare, and treatment outcomes differed for families served through FTDCs as compared to families who received traditional child welfare services. An initial, retrospective study (Phase I) included administrative data collection on small samples of FTDC and comparison cases at the four sites. A larger, prospective study (Phase II) included both administrative and interview data collection on larger samples of parents.

Family Treatment Drug Courts: An Innovative Approach to Serving Substance-Abusing Parents in the Child Welfare System

According to the U.S. Department of Health and Human Services, during fiscal year 2003-2004, over 900,000 children were victims of parental neglect or abuse (DHHS, 2004). It is estimated that parental substance abuse is a significant contributor to child maltreatment in between 40-75% of all child welfare cases (Magura & Laudet, 1996; Murphy, Jellnick, Quinn, Smith, Poitrast, & Goshko,

1991; National Center on Addiction and Substance Abuse, 1999). Moreover, children whose parents abuse substances stay in foster care longer and have the lowest probability of successful reunification with their parents (Green, Rockhill, & Furrer, 2006; Gregoire & Shultz, 2001; Murphy et al., 1991; Tracy, 1994).

The challenge of serving these families effectively has been highlighted by a number of studies (DHHS, 1999; Rockhill, Green, & Furrer (2007); Semedei, Radel, & Nolan, 2001; Young, Gardner, & Dennis, 1998), and is complicated by the federal Adoption and Safe Families Act (ASFA, 1997). This legislation mandates a one-year timeline for parents to comply with court-ordered reunification requirements, including recovery from addiction. Parents who do not comply within this timeline face permanent termination of their parental rights. In the face of ASFA's stringent requirements, child welfare and treatment systems have embraced innovative strategies for serving substance-abusing parents. One of the fastest-growing program models for serving these families is the Family Treatment Drug Court (FTDC; also known as Dependency Drug Courts or Family Treatment Courts).

As of April 2006, there were 183 FTDCs operating in 43 states in the U.S., and over 100 additional programs in development (BJA Drug Court Clearinghouse, 2006). These courts serve thousands of substance abusing parents, and the rapid proliferation of this model makes it likely that many more families will receive FTDC services in the next five years. Modeled after adult (criminal) drug courts, FTDCs incorporate some similar elements, but under a very different set of circumstances. The FTDC, like adult drug courts, includes regular (often weekly) court hearings, intensive judicial monitoring, provision of substance abuse treatment and other wrap-around services, frequent drug testing, and rewards and sanctions linked to service compliance. However, FTDCs represent a unique service model, and differ from adult drug courts in important ways. First, the majority of adult drug court participants are male, whereas females comprise more than 85% of those served by FTDCs (Cooper, 1998; Edwards & Ray, 2005). Second, FTDC participants are involved with services due to non-criminal issues related to child maltreatment, and criminal sanctions are generally not employed. Thus, while adult drug court services are typically offered in lieu of jail time, the primary motivation for participation in FTDCs is the prospect of family reunification – put another way, the "threat" for adult drug court participants is incarceration, while the "threat" for FTDC participants is losing custody of their children, often permanently. Third, FTDCs address complex family systems and family needs that are rarely a part of adult drug court proceedings (Edwards & Ray, 2005). FTDCs not only deal with the issues of the client but the surrounding issues facing the child(ren). In addition to treatment, parents involved with FTDCs often have many other issues that must be dealt with in order to be reunified with children, including employment, housing, and parenting practices. Thus, unlike adult drug court, successful treatment does not necessarily guarantee ultimate success in the FTDC context, and the relationship between parents' engagement in treatment and other services, treatment success, and family reunification remains an important unanswered question.

Despite these differences between adult drug courts and family treatment drug courts and the rapid proliferation of FTDCs, the model has not been systematically tested or rigorously evaluated. Indeed, noted adult drug court researcher Steven Belenko states that with "the strong recent interest in juvenile and family drug courts, and the very different operational and treatment issues involved, it will be important over the next few years to build a body of research comparable to that for adult drug courts," (Belenko, 1999, p. 48). The national Family Treatment Drug Court Evaluation is a first step in building this knowledge base.

The National Family Treatment Drug Court Evaluation

In 2002, the United States Department of Human Services Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) contracted with NPC Research to conduct an evaluation of four FTDCs located in San Diego and Santa Clara Counties, California; Suffolk County, New York; and Washoe County, Nevada. These four FTDCs were chosen by CSAT from a group of seven programs that expressed interest in participating in the study; the chosen sites were selected

based on estimates of adequate sample sizes and the availability of data. The study included both parent interview data collection and administrative data collection from court, child welfare, and treatment data sources. Below are brief descriptions of the study sites; for a detailed description of the study methodology, please see Chapter 2.

San Diego, CA: The San Diego Dependency Court Recovery Project serves every identified substance-abusing parent involved with the child welfare system through a system-wide reform adopted in 1998. The program involves two levels of service for parents identified with substance abuse problems. Substance Abuse Recovery Management Services (SARMS) are provided to all parents with substance abuse problems and include assignment to a specialized case manager, immediate assessment and referral to appropriate substance abuse treatment services, and frequent drug testing. Clients who fail to enroll in treatment services or who are noncompliant with treatment services are offered the second level of service, which is the more intensive Dependency Drug Court. Clients in the drug court receive more intensive and frequent case management, additional judicial oversight (in the form of more frequent hearings), and additional wraparound services. Approximately 10% of all SARMS cases go on to enter the Dependency Drug Court. Thus, this site represents the least traditional drug court model, as a number of clients receive case management and recovery support, and only those with more difficulty in recovery participate in the more intensive Dependency Drug Court. This program, located in a large metropolitan region, draws from a large pool of treatment services and options for the parents; indeed, parents can be referred to any one of several dozen treatment providers, including a variety of residential and outpatient modalities.

Santa Clara County, CA: Santa Clara County's Dependency Drug Treatment Court began in 1998, and in 2003 the county began a system-wide reform effort modeled on San Diego's Dependency Court Recovery Project. Under Santa Clara's system reform, all substance abusing parents involved with the child welfare system are referred to a substance abuse assessment and receive an extra hearing 45 days after petition to gauge parental needs and progress with case plan requirements. Those parents who need extra support are referred to the FTDC. The program has a substantial transitional housing service, uses FTDC graduates as mentors for current FTDC participants, and has a Head Start program that provides services and parenting classes to FTDC parents. Clients are referred to a variety of treatment services, including short- and long-term residential treatment and a variety of outpatient treatment providers.

Suffolk County, New York: Founded in 1997, Suffolk County's Family Treatment Court serves substance-abusing parents whose cases involve neglect allegations only, thus in contrast to the other sites, children in the Suffolk samples are less likely to be removed from the parents' custody. In addition to traditional FTDC services, this program offers Court Appointed Special Advocates who conduct individual family meetings and regular case conferences with CPS and other team members. As with San Diego and Santa Clara Counties, Suffolk County refers drug court parents to a wide variety of treatment providers throughout the county.

Washoe County, Nevada: Washoe County's Family Dependency Court was established in 1994 (indeed, this is the oldest FTDC in the nation) and serves parents with both abuse and neglect cases. In addition to traditional FTDC services, this site uses Foster Grandparents as mentors for participants and has weekly team meetings to discuss and monitor participants' progress. Unlike the other study sites, at the time of our sample building and data collection, Washoe County's FTDC had contracts with just three treatment providers; all drug court parents were referred to one of these three providers for residential or outpatient treatment.

Contents of This Report

This report presents the findings of the second (larger) phase of the FTDC Evaluation. Results from Phase I can be found in Green, Furrer, Worcel, & Burrus (2007). The next chapter details the evaluation methodology. Chapter 3 presents data comparing outcomes for drug court cases with outcomes for cases receiving traditional child welfare case processing. Chapter 4 provides a closer look at parent characteristics and experiences, including parent psychosocial characteristics and parent perceptions of the services they have received. Chapter 5 links the drug court and treatment experiences and parent psychosocial characteristics with key treatment and child welfare outcomes, and also uses qualitative data to examine the key ingredients of drug courts and the challenges raised by judicial transitions. The final chapter of the report includes our conclusions and recommendations for practice and further research.

CHAPTER 2: STUDY DESIGN AND METHODOLOGY

In this chapter we present the study research questions and design, including a discussion of the administrative and interview components of the study.

Research Questions

The FTDC Evaluation explored not only *whether* drug courts work, but also *how* they work and for *whom* they work[1]. The evaluation was guided by a set of research questions created by NPC in collaboration with CSAT and the study sites. A logic model showing the overall framework for the research questions is shown in Figure 1. To answer research questions about *whether* drug courts work, we investigated differences between drug court cases and comparison cases on child welfare outcomes (such as reunification and time to permanency) as well as on treatment outcomes (such as time spent in treatment and treatment completion). To answer questions about *how* and for *whom* drug courts work, we investigated parents' psychosocial characteristics, their drug court experiences, and how these characteristics and experiences related to outcomes.

FTDC OUTCOME QUESTIONS

A primary purpose of the FTDC Evaluation was to document *whether* differences in outcomes exist between drug court system cases and comparison cases. The outcomes investigated included treatment system outcomes, child welfare system outcomes, and court system outcomes.

Treatment System Outcome Questions

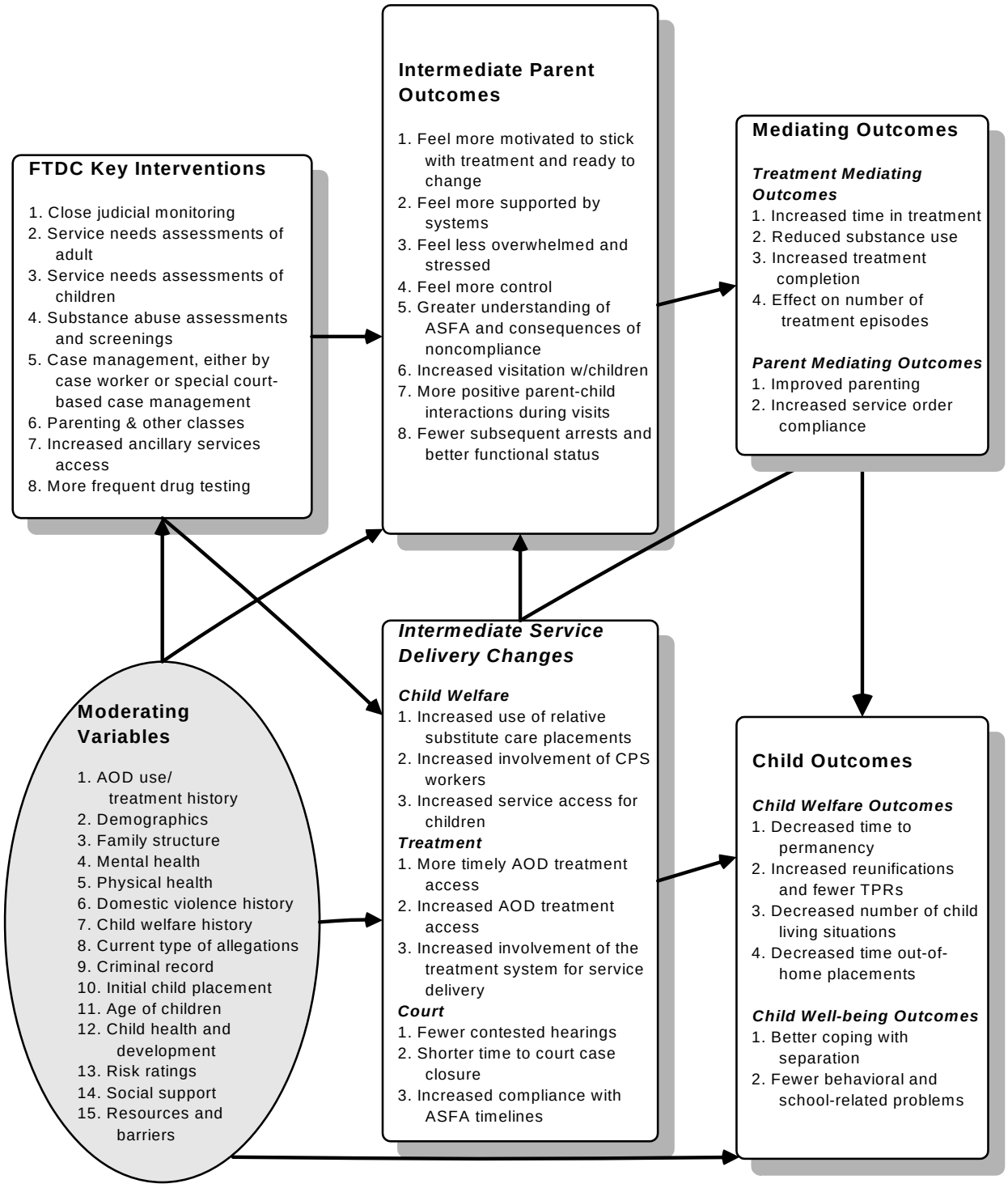
1. Do drug court system parents enter substance abuse treatment at a higher rate than comparison parents and do they enter treatment more quickly than comparison parents?
2. Do drug court system parents spend more total days in treatment than comparison parents?
3. Are drug court system parents more likely to complete treatment during the case than comparison parents?

Child Welfare System Outcome Questions

1. Do drug court system children receive more services to address their needs than comparison children?
2. How do drug court system children's living situations differ from comparison children? Specifically:
   a. Do drug court system children have fewer changes in living situation during their case than comparison children?
   b. Do drug court system children spend less time in out-of-home placements during their case than comparison children?
   c. Do drug court system children spend more time in kinship out-of-home placements than do comparison children?

[1] Throughout this report we use the term "drug court" to mean Family Treatment Drug Courts.

Figure 1. FTDC Evaluation Logic Model



3. How do permanency outcomes differ for drug court system children as compared to comparison children? Specifically:
    a. Is time to permanency different between drug court system families and comparison families?
    b. Are reunifications achieved more often for drug court system families than for comparison families?
    c. Are terminations of parental rights less frequent for drug court system families than for comparison families?
4. Do drug court system parents have less child welfare recidivism than comparison parents? Specifically:
    a. Are drug court system parents less likely to have a subsequent petition added to their original cases than comparison parents?
    b. Are drug court system parents less likely to have a subsequent ***substantiated referral*** to CPS than comparison parents?
    c. Are drug court system parents less likely to have a new ***family/dependency court petition*** than comparison families?
    d. Are drug court system parents less likely to have a subsequent ***out-of-home placement*** for their children than comparison parents?
    e. Are drug court system parents less likely to have a subsequent ***termination of parental rights*** than comparison parents?
    f. Are drug court system parents less likely to have a subsequent ***birth involving a positive toxicology screen*** than comparison parents?

Court System Outcome Questions

1. Do parents in drug court system cases have greater service order compliance than comparison parents?
2. Do drug court system cases take less time to case closure than comparison cases?

QUESTIONS ABOUT DRUG COURT SYSTEM PARENTS' PSYCHOSOCIAL CHARACTERISTICS AND DRUG COURT EXPERIENCES

The FTDC Evaluation included a parent interview component that allowed for the collection of detailed information on parental psychosocial characteristics to paint a descriptive picture of the types of parents participating in drug court services. In addition to allowing for the collection of information on parental psychosocial characteristics, the parent interview also included a series of questions to gather information about drug court experiences. Specifically, these data address the following questions:

Parents' Psychosocial Characteristics

1. How much past and current substance use do drug court system parents report?
2. How much social support do drug court system parents have?
3. How much social support for recovery do drug court system parents have?
4. How motivated and ready to change are drug court system parents?
5. What are drug court system parents' psychiatric histories and status?
6. How overwhelmed and stressed do drug court system parents feel?

7. How in control do drug court system parents feel over the outcome of their case?
8. What are parents' parenting skill levels?

Parents' Drug Court Experiences

1. How long does it take parents to enter drug court, and how long do they stay in drug court?
2. How many drug court appearances do parents have?
3. How many parents graduate from drug court?
4. How appropriate and accessible do parents perceive their treatment services to be?
5. Are parents receiving the ancillary services they believe they need?
6. Do parents report that ancillary services are helpful?
7. How frequently do drug court system clients meet with helping professionals such as their child welfare social workers, treatment counselors, attorneys, and drug court case managers?
8. How supported do drug court system parents feel by child welfare, treatment and judicial systems?

Parents' Experiences with Children

1. How positive are drug court system parents' parenting skills?
2. How often do parents visit with children?
3. How positive are the interactions between drug court system parents and children during visits?
4. How do drug court system parents perceive that their children are coping with separation?
5. Do drug court system parents perceive that their children are having problems?
6. Do drug court system parents believe their children are receiving needed services?

RELATIONSHIP BETWEEN THE DRUG COURT INTERVENTION AND OUTCOMES

Data from the administrative and interview components of the study allow for an examination not only of *whether* drug courts work, but if so, *how*. The evaluation included a series of research questions aimed at investigating the "black box" of family treatment drug courts in order to examine the relationship between parent characteristics, drug court services and experiences, and key treatment and child welfare outcomes.

1. What is the relationship between ***drug court dosage*** (including time to drug court entry, time spent in drug court, number of drug court appearances, drug court graduation, and frequency of meetings with helping professionals***)*** and treatment and child welfare outcomes?
2. What is the relationship between ***treatment experiences*** (including time to treatment entry, time spent in treatment, treatment completion, and treatment accessibility) and treatment and child welfare outcomes?
3. What is the relationship between ***parents' quality of relationships with helping professionals*** and treatment and child welfare outcomes?
4. What is the relationship between parents' ***psychosocial characteristics*** (e.g. demographic characteristics, social support, perceived stress, treat-

ment motivation) and treatment and child welfare outcomes?

Research Design

The evaluation used two different non-equivalent control group designs: a within-county comparison group design for the Washoe County and Suffolk County sites, and a comparison county design in Santa Clara and San Diego[2].

In Suffolk and Washoe Counties, and for the first two years of the study in Santa Clara, there were sufficient numbers of FTDC-eligible cases that received traditional child welfare case processing to allow for within-county comparison groups. Eligible parents did not enter the drug courts for a variety of reasons, including capacity constraints, social workers or attorneys not making the appropriate referrals to drug court (or in some cases, actively discouraging their clients from entering drug court), and parents refusing drug court services.

The research design for San Diego utilized a comparison group drawn from similar California counties that did not have an FTDC or other specialized program for substance abusing parents. This was necessary due to San Diego's system-wide reform, which meant that by definition there were no untreated families within the county who could be used as a comparison group. In Santa Clara, we began by sampling within-county comparison group clients using procedures similar to Washoe and Suffolk. However, midway through this study Santa Clara redesigned its program, moving toward a more systemic approach; because of this, we also included comparison families from two comparison counties in the analysis of the Santa Clara site[3]. NPC gained cooperation from two other California counties to serve as comparison counties. We selected these counties from a pool of eight populous California counties. We examined the counties on a number of indicators, including population, level of poverty, median incomes, percent Hispanic and African American, number of children, number of child welfare cases, treatment admissions, drug arrests, and whether the counties had family drug courts. Three counties emerged as sufficiently comparable to San Diego and Santa Clara on a variety of indicators, and most importantly, none of these three counties had their own family drug courts. Two of these three counties agreed to participate in the study.

Below we detail the methodology used for the two primary components of the study: the administrative data component and the interview data component.

ADMINISTRATIVE COMPONENT METHODOLOGY

The study relied upon administrative data from county- and state-level child welfare, court, and treatment databases and paper records. Two years of administrative data were collected on each study case. In this section we describe the ad-

[2] The design at the Santa Clara site actually pooled both within-county comparison families and comparison families drawn from the two comparison counties. Because families were well-matched within the comparison counties, this allowed us to increase the sample size, and thus the statistical power of the impact analysis within this site.

[3] However, it should be noted that the system reform as implemented during this study period ultimately did not provide extensive services to families not referred to drug court. Non-drug court families received only substance abuse assessment and one additional court hearing. Therefore, the final sample included these post-systems change, non-FTDC families as comparison (non-FTDC) parents.

ministrative component sampling methods, the data collection instruments, and the strategies used for ensuring data integrity.

Administrative Sampling Methods

The sampling methods differed slightly for each site; below we summarize the site-specific sampling strategies. See Appendix A for sample descriptive statistics.

San Diego County Administrative Sample Building. The San Diego administrative sample was drawn from cases that entered SARMS and the Dependency Drug Court between 2000 and 2005, and included 355 SARMS and 122 Dependency Drug Court participants for a total sample size of 477.[4] Approximately 55 cases were randomly selected each year (45 SARMS and 10 Dependency Drug Court) for 2000-2002 and approximately 120 cases were selected each year (90 SARMS and 30 Dependency Drug Court) for 2003 and 2004. In addition, a small number of cases (n=18) were drawn from 2005 to complete the interview subsample (see pages 15-16 for more information on this component). Our sample building began in December 2003, and therefore we describe separately our method for building the sample of cases that entered the child welfare system *prior* to December 2003 and our method for prospective sampling of those cases that entered the system after that month.

Pre-December 2003 cases: We received a list from the SARMS Coordinator of all individuals who enrolled in SARMS and the Dependency Drug Court between January 2000 and November 2003. From this list we selected study participants to meet our target numbers for each year. Thus, we randomly selected approximately four SARMS and one Dependency Drug Court case each month for cases that began in 2000-2002, and approximately eight SARMS and three Dependency Drug Court cases each month for cases that began between January and November 2003.

Post-November 2003 cases: Beginning in December 2003, we received, on a weekly basis, lists of parents who became involved with SARMS and the Dependency Drug Court. From these lists we planned to select approximately ten SARMS and three Dependency Drug Court cases each month for the study sample. However, after December 2003 the case flow into the Dependency Drug Court was low; most months there were less than three parents admitted, and therefore we included every Dependency Drug Court case, and over-sampled SARMS participants in order to meet our overall sample size goal.

Santa Clara County Administrative Sample Building. The Santa Clara administrative sample also was drawn from cases that began in 2000 through 2005, and included a total of 475 cases: 194 pre-system change comparison cases, 183 post-system change comparison cases, and 101 Dependency Drug Treatment Court (DDTC) cases (approximately half pre-system reform and half post-system reform). Approximately 74 cases were selected each year (60 non-drug court and 14 DDTC) for 2000-2002 and 120 cases were selected each year (90 non-drug court and 30 DDTC) for 2003 and 2004. In addition, we added 26 cases that began in 2005 to the final administrative data sample due to continued recruitment for the interview sub-sample (see pages 15-16 for a description of this component). Our sample building began in March

[4] In our analysis we weighted the total San Diego sample to reflect the proportion of SARMS and DDC clients in the overall system (90% SARMS, 10% DDC).

2004, and therefore we describe separately our methods for building the sample of cases that entered the child welfare system *prior* to March 2004 and those cases that entered the system after that month.

Pre-March 2004 cases: We received a list from the county child welfare information services department of cases that had petitions filed between January 1, 2000, and February 29, 2004. This query generated a list of petition dates and CWS/CMS numbers. This list included hundreds of cases for each year, and therefore, we did not review every case on the list to determine study eligibility. Instead, we reviewed the cases from each month to find those with alcohol or drug use allegations that did not meet drug court exclusionary criteria (extreme mental illness, voluntary cases, and fast-track cases). The sample consists of 60 non-DDTC and 14 DDTC clients per year for years 2000-2002. For the 2003 and 2004 sample we selected approximately seven non-DDTC and two DDTC clients from each month until we reached our targeted sample of 90 DDTC and 30 DDTC clients for each year.

Post-February 2004 cases: Beginning in March 2004 we received, on a weekly basis, lists of parents with substance abuse issues identified on the petition, who were either served through the DDTC or with the "system reform" services (one additional hearing plus substance abuse assessment). Originally, we planned to sample from this list, but due to low caseflow we included all eligible persons during this time period in the sample.

California Comparison Counties Administrative Sample Building. At each California comparison county we selected 399 cases that entered the child welfare system between January 1, 2000, and September 30, 2004. For the years 2000-2002 we selected 34 cases per year from each county, and we selected approximately 50 cases per year for 2003 and 2004. We employed aggregate matching in order produce samples that approximated San Diego and Santa Clara in terms of parent gender, parent race, age of children, prior involvement with child welfare, and concurrent criminality; at each comparison county approximately half the sample was matched to San Diego and the other half was matched to Santa Clara.

The sample selection process in the comparison counties mirrored the pre-March 2004 sample selection process in Santa Clara County. In each county, information services department staff generated a list of petitions, and we reviewed cases to determine study eligibility. Then, using our matching criteria, we selected approximately three cases each month from each comparison county for inclusion in the comparison samples.

Suffolk County Administrative Sample Building. In Suffolk County, a total of 400 cases (132 drug court and 268 comparison cases) that began between July 2002 and December 2005 were included in the administrative samples. In Suffolk County we reviewed the FTC database for cases alleging parental substance abuse that were referred to FTC for consideration between July 2002 and December 2005. We tracked FTC admissions, and these individuals were included in the FTC sample. Those parents not admitted to FTC who did not meet the FTC exclusionary criteria (extreme mental illness, allegations of abuse other than neglect, history of violence, voluntary cases, and fast-track cases) were included in the comparison sample.

Washoe County Administrative Sample Building. In Washoe County, 215 cases (87 drug court and 128 comparison cases) that began between July 2002 and July 2005 were included in the administrative sample. In Washoe County we reviewed all petitions filed between July 2002 and July 2005 for allegations of substance abuse using the Unified Information Technology Child Welfare (UNITY) database. Next, on an ongoing basis, the site research coordinator identified new admissions into the Family Drug Court (FDC) by conducting a review of the minutes from the FDC Policy Committee's Core Review Team Weekly Meeting that screens and "pre-qualifies" referrals from CPS social workers, and by attending the weekly pre-hearing team meetings to confirm the formal acceptance of those referrals. Those individuals who were admitted into the FDC were selected for the FDC sample. For those people not referred or enrolled in the FDC, the site research coordinator determined whether the case met drug court exclusionary criteria (extreme mental illness, history of violence, voluntary cases, and fast-track cases), which resulted in exclusion from the comparison group as well. The site research coordinator enrolled in the administrative data sample all individuals who entered the FDC or met the eligibility criteria for the comparison group.

Table 1. Total Study Sample Sizes

Site	FTDC	Comparison (non-FTDC)	Total
San Diego			
N	122 (drug court) 355 (SARMS)	NA	477
Sample Years	2000-2005		
Santa Clara			
N	101	194 (pre-system change) 183 (post-system change)	478
Sample Years	2000-2005	2003-2005	
CA Comparison Counties	NA	399	399
N		2000-2005	
Sample Years			
Suffolk			
N	132	268	400
Sample Years	2002-2005	2002-2005	
Washoe			
N	87	128	215
Sample Years	2002-2005	2002-2005	
Total	802	1,167	1,969

For the purposes of the analyses presented in the remainder of this report, we have focused on cases that included **mothers** involved with drug court and comparison cases with mothers (95%, or 1,863 of the study cases). Fifty-eight percent (1,149) of the study cases included both mothers and father/father figures, and a handful of cases (3%) consisted of father-only families. While there are numerous research questions that could be posed about the outcomes for two-parent families as compared to single parent families, or for mothers as opposed to fathers, these questions were outside the scope of the current study. Therefore we have restricted our analysis to outcomes for mothers and their children.

Table 2. Sample Sizes – Mothers Only

Site	FTDC	Comparison	Total
San Diego			
N	104 (drug court) 334 (SARMS)	NA	438
Santa Clara			
N	100	190 (pre-system reform) 180 (post-system reform)	470
CA Comparison Counties N	NA	388	388
Suffolk			
N	117	239	356
Washoe			
N	84	127	211
Total	739	1,120	1863

Appendix A includes tables listing the demographic, substance use history, child welfare case characteristics, and parent and child risk factors for the cases included in this report.

Administrative Data Instrument

Administrative data for this study were gathered from child welfare, court, treatment, and criminal justice sources using a 39-page instrument consisting of five forms:

- Form 1, Parent Information: Basic information about parents' race/ethnicity, education, employment, financial resources, CPS allegations, mental and physical health, and children;
- P2, Case Detail: Parents' SARMS or FTDC status, court hearings and CPS compliance, FTDC hearings, court orders, urinalysis tests and results, visitations, children's assessments and services, and children's placement changes;
- P3, Case Outcome: Children's permanency and adoption status;
- P4, Treatment Detail: Parents' AOD treatment assessments and episodes; and
- P5, Child Welfare Recidivism: Details of parent's CPS recidivism.

The format of the data varied by site and by data source; some data were transferred electronically to NPC, other data was housed electronically but needed to be extracted by hand onto the above forms, and some data were extracted onto the above forms from hard copy files.

Strategies for Ensuring Data Integrity and Reliability

Collecting data across sites (and across sources within each site) posed challenges for ensuring that data were collected in a consistent manner. The evaluation team, therefore, employed several strategies for ensuring the reliability and validity of the administrative data. First, research staff at all sites took part in intensive training to become familiar with the operational definitions for all variables on the administrative data collection tool. Detailed operational definitions for each variable for each site were constructed and used continually throughout data collection. Operational definitions included guidance as to issues such as which data source to prioritize in cases of discrepancies, and the extent of documentation needed to code particular variables (e.g., mental health status). In addition to initial training, site staff took part in regular conference calls to address questions and to receive ongoing training, and site staff were in frequent (in some cases almost daily) email and phone contact with NPC supervisors to answer questions as they arose.

In addition to training and technical assistance to site staff, NPC employed rigorous data processing techniques. Each completed administrative data collection tool was reviewed to check for missing information and for logical inconsistencies, and site staff were asked to address and remedy any such problems. Once the data were processed and entered, NPC's data processing staff conducted regular data entry quality control checks, and ongoing cleaning of the entered data.

INTERVIEW COMPONENT METHODOLOGY

Interview data were gathered on a subset of parents from the administrative FTDC samples at all sites[5]. Interviews were conducted soon after parents' enrollment in the FTDCs (typically within 30-60 days) and then at 6-, 12-, and 18-month follow-up points. These interviews allowed the evaluation team to gather information from parents about their perceptions of their drug court experiences along with information about their psychosocial characteristics.

Below we describe the interview sample selection strategy, interview recruitment, the interview instrument, and the strategies used for ensuring data integrity.

Interview Sample Selection

Interview sample selection procedures differed across the four study sites, as described below.

San Diego Interview Sample Building Procedures. The final San Diego interview sample consisted of 90 parents (10 drug court and 80 SARMS) whose cases began between December 2003 and June 2005. Our interview sample building procedure in San Diego involved the help of SARMS and drug court staff to obtain permission from clients to be contacted by the researchers ("consent to contact;" San Diego was the only site at which this procedure was necessary). SARMS Recovery Specialists (equivalent to drug court case workers) introduced the study and provided the recruitment flyer to all newly entering SARMS clients at the initial substance abuse assessment. For clients that were new to drug court, the Drug Court Recovery Specialist provided the flyer at the drug court orientation. The Recovery Specialists had clients sign a consent to contact document if they were willing to be approached by the researchers. The Recovery Specialists also completed tracking forms listing basic demographic information for all clients to whom they presented the study, and indicating which clients signed a consent to contact form. NPC's site research coordinator compared these tracking sheets weekly to a list of all newly admitted SARMS and drug court parents to be sure that all eligible study participants had been informed about the study. During the recruitment period, 354 parents were presented with a study flyer and asked to sign a consent to contact; 204 of these parents (58%) agreed. Men were slightly more likely than women to agree to be contacted, and Hispanics were slightly more likely than Caucasians and African Americans to agree to be contacted. We selected a random sample from the 204 parents who signed a consent to contact form to contact about the research. These parents were also included in the administrative sample described above. Analyses of interview data presented in Chapters 4 and 5 of this report include only mothers (n=67).

Santa Clara Interview Sample Building Procedures. In Santa Clara County, the interview sample consisted of 30 drug court parents whose cases began between December 2003 and June 2005. Unlike in San Diego, sampling was not necessary in Santa Clara due to low case flow, and therefore all parents between December 2003 and June 2005 were included as potential participants in the interview sample; these parents received recruitment

[5] The initial study design included collecting interview data from comparison (non-FTDC) parents as well. In fact, 79 comparison group interviews were collected before a decision was made to eliminate this component of the study due to the difficulty and cost of identifying and recruiting comparison parents.

flyers at their detention hearings. These parents were also included in the administrative sample described above. Additionally, 54 parents were interviewed who received "Tier One" services after the system reform; however, these parents were not included in later analysis. Analyses presented in Chapters 4 and 5 of this report include only mothers (n=28).

Suffolk Interview Sample Building Procedures. In Suffolk County, the interview sample consists of 30 drug court parents whose cases began between December 2003 and December 2005. Recruitment flyers were presented to new drug court parents at their first drug court session. As in Santa Clara County, all newly enrolled drug court participants (during the sampling window) were included as potential participants in the interview sample (these parents were also included in the administrative sample described above). Analyses presented in Chapters 4 and 5 of this report include only mothers (n=24).

Washoe Interview Sample Building Procedures. In Washoe County, the interview sample consisted of the 17 parents (all mothers) who entered drug court between December 2003 and June 2005. New drug court participants received recruitment flyers in their drug court orientation packet. All newly enrolled drug court participants were included as potential participants in the interview sample (these parents were also included in the administrative sample described above). These parents represented 100% of the FTDC parents processed during this time period.

Interview Participant Recruitment

NPC site staff used a variety of techniques to contact and recruit parents into the interview component of the study. Research staff contacted parents by phone, by mail, and in-person (either by attending drug court or dependency court hearings or by visiting the parents' residences). NPC Research staff were in close contact with case workers and other staff at each site in order to obtain the most up-to-date contact information available on all potential study participants. Our varied modes of contact were successful; recruitment rates across our four sites were at or above 84%[6]. Table 3 lists the overall retention rates at each site for all treatment group interview study participants.

Interview Instrument

The parent interview collected information about the parent, including demographics, resources and barriers, alcohol and drug use, treatment and ancillary services, court and CPS experiences, self perceptions, and opinions on program components. In addition, the interview collected information on children, including parent-child visitation and parental perceptions of child well-being. Although some items needed only to be asked at baseline, most items were repeated in follow-up interviews to record changes over time. Below are descriptions of the specific topic areas addressed by the interview. A copy of the instrument is included in Appendix B.

Demographics: This section collected information on a variety of topics, including: age, ethnicity, race, education, employment, public assistance, marital status, living situation, and transportation options. No standardized scales were

[6] This recruitment rate is based on recruitment after the initial consent to contact phase; for example, in San Diego, of those who consented to contact and whom we attempted to contact, 87% agreed to participate.

used in this section, although many of the demographic questions (ethnicity and race, for example) followed the U.S. Census conventions.

Parental motivation for treatment: By collecting information on treatment motivation, we could gauge changes in denial, readiness, and other precipitating factors in treatment participation and behavior change. The TCU Treatment Motivation Scale (TCU Institute of Behavioral Research, 2002) is a 29-item scale used to assess the role of treatment motivation in four areas: problem recognition, desire for help, treatment readiness, and external pressures. These subscales have been associated with treatment retention in several settings.

Substance use history: To measure parents' substance usage, we used the ASI Lite, a widely used measure of addiction severity, the reliability and validity of which has been established for a variety of populations. This measure is one of the Center for Substance Abuse Treatment's core measures.

Parental perceptions of treatment access and appropriateness: We asked several questions, developed for this study, to solicit parents' perceptions of how easy or hard it has been for them to access treatment as well as how appropriate they feel their treatment referrals have been.

Social support for recovery: It was important that we capture social support specific to substance abuse recovery, as having the support of spouses, family, and friends for substance abuse recovery can be a crucial moderating factor for ultimate success. We developed these items for this study.

Table 3. Interview Sample Size and Retention Rates

	Baseline Interviews N	6-Month Interviews N (% retention)	12-Month Interviews N (% retention)	18-Month Interviews N (% retention)*
San Diego	90	76 (84%)	78 (87%)	77 (86%)
Santa Clara	30	29 (96%)	29 (95%)	26 (86%)
Suffolk	30	23 (75%)	27 (91%)	24 (80%)
Washoe	17	17 (100%)	16 (92%)	14 (80%)

* Because the initial recruitment window was extended in order to try to increase sample size, not all participants were eligible for the 18-month interview. Thus, these retention rates include only those participants who reached the 18-month assessment window.

Service delivery: This section asked about services obtained by the parents along with who provided the services and how helpful the parents found each service. For example, parents were asked whether transportation issues were a barrier to successful treatment and reunification with their child(ren), and if so, whether they received transportation assistance, in which case they were asked who provided it and how helpful it was. These questions were asked for a variety of services, including housing assistance, employment assistance, mental health assistance, and relationship services. We developed these items for this study.

Intervention frequency: FTDCs are modeled to provide coordinated service and frequent interactions with participants. Therefore, we asked a set of questions to determine whether parents received a variety of services and interactions. We developed these items for this study.

Quality of relationships: We developed a measure of the quality of the relationship between the client and key service providers. Evidence from adult drug court suggests that the relationships established between the client and the judge or referee, caseworker, treatment provider, and attorney are critical to client progress.

Perceived stress: We hypothesized that the coordinated system of services provided to families in FTDCs may result in the reduced stress. We measured overall stress levels using the Perceived Stress Scale, a 5-item standardized tool (Cohen, Karmarck, & Mermelstein, 1983).

Parents' perception of control: Parents going through FTDC might be expected to have a greater sense of mastery and control over the family court and treatment process. It is domain-specific aspects of control that we expected to be most influenced by the FTDC, rather than general perceptions of control, and therefore, we modified questions from the Family Empowerment Scale (Koren, DeChillo, & Friesen, 1992), a standardized measure of family perceptions of control over children's early intervention services, to reflect child welfare and FTDC services.

Parenting skills: Parenting skills, as a stepping-stone to the ultimate program outcome of reunification, could be a key mediating outcome variable. We used several subscales from the Adult-Adolescent Parenting Inventory (Bavolek & Keene, 1999). This inventory measures attitudes toward childrearing that have been linked to child abuse.

Visitation: Regular visitation between parents and children is an important mediator of ultimate reunification. We have developed questions to ask parents about not only the frequency and regularity of visits, but also their feelings about the visits, and their perceptions of their child's feelings. Parents who had more than one child removed from their care were asked to focus on one child in order to answer these questions. The interviewers selected the target child for each parent by selecting the child whose birthday was closest to January 1.

Social support: Social support can play a vital role in moderating parents' success with treatment and reunification. We used a shortened version of the Interpersonal Support Evaluation List (Cohen et al., 1985), comprising 10 items from this standardized measure of social support.

Parental perceptions of child well-being: While this evaluation was not seeking to address the ultimate child well-being outcomes that may be attributable to FTDCs, we were able to ask

parents their perceptions of their children's well-being. Again, parents were asked to focus on one child when answering these questions. In addition, parents were asked to report whether or not children had experienced a series of behavioral or other problems since being removed from parental care. These items are drawn from the Social Skills Rating Scale (Elliot et al., 1988).

Understanding of ASFA: We developed several items to measure parents' understanding of ASFA and the child welfare process, including what they need to do to be reunited with their children (for those children in out-of-home placements) and what they need to do to complete their service plan.

Psychiatric Status: We used the psychiatric subscale of the ASI to gather information about parents' current and past mental health issues.

Strategies for Ensuring Interview Data Integrity

The quality of the data gathered through structured, quantitative interviews such as the one employed in this study is dependent in large part on the extent to which the interviewers adhere to the interview protocol. NPC therefore employed several strategies to ensure high quality interview data. First, interviewers completed a rigorous training program that culminated in a certification test; prior to passing this test no interviewer could begin interviewing. Interviewers took part in regular conference calls throughout the course of the project to share experiences and gain support from one another; these calls also gave an opportunity for NPC to provide refresher trainings. Interviewers also taped their first five interviews as well as additional interviews over the course of the project; NPC supervisors reviewed these tapes and provided feedback on interviewing style and fidelity. Finally, NPC supervisors placed telephone calls to 5% of the interview participants (randomly selected) to obtain feedback, from the participants, about their interview experience. These calls allowed NPC to verify that the interviewing experience was a pleasant one for the participants and allowed participants to share any feedback they had.

NPC's data processing strategies for the interview data were similar to the strategies employed for the administrative data. All completed interviews were reviewed upon receipt to check for missing information and logical inconsistencies; these issues were brought back to the attention of the interviewers. While the administrative data was hand-entered, interviews were scanned using scanning software; this software was programmed to provide error messages for missing information and incorrect skip patterns, thus providing a second level of data cleaning.

CHAPTER 3: FTDC OUTCOMES

In this chapter, we present results for the primary research questions addressing whether outcomes for mothers receiving Family Treatment FTDC services were significantly different from outcomes for mothers processed through traditional child welfare systems. First, we briefly describe the analytic approach used for the outcome analyses, followed by the analyses for treatment, child welfare, and court outcomes.

Analysis Approach

Comparing FTDC families to families that did not participate in FTDC (comparison families) is complicated by the fact that FTDC families may systematically differ from comparison group families, and those differences, rather than FTDC, may account for some or all of the observed differences in the outcome measures. To address this complication, we used a method called *propensity score analysis* because it provides some control for differences between the FTDC families and the comparison families given our comparison group design (see Rosenbaum & Rubin, 1983).

The first step of propensity score analysis is to estimate the probability that a study family will or will not be a FTDC participant. We used a number of mothers' characteristics to calculate the probability that a study family participated in FTDC: 1) race, 2) marital status, 3) education level, 4) employment status, 5) age, 6) previous CPS involvement, 7) parental risk factors, 8) age of first drug use, 9) previous TPR, 10) type of abuse allegation, 11) number of children involved in the child welfare case, 12) children's risk factors, 13) whether an infant was involved in the case, and 14) frequency of

drug use. This estimated probability is known as the *propensity score*.

The second step is to estimate the treatment effect (the extent to which drug court system mothers differed from comparison mothers) for each site using Weighted Least Squares (WLS) regression. This was done using propensity scores to weight the parameters in the estimation equation, thereby adjusting for the pre-existing differences between the two groups. The third step is to analyze the effect of FTDCs across all sites in order to arrive at a pooled estimate of the treatment effect. The means and variance estimates used in this step were adjusted to control for within-site FTDC vs. comparison family differences on the previously mentioned variables.

Because our overall sample size is large, it is easy to have statistically significant pooled findings that may not be of practical significance. To supplement our interpretation of the pooled treatment effects, we also calculated an effect size for each outcome (Cohen's *d*). An effect size is a measure of association, or an estimate of the variance accounted for in an outcome that can be attributed to the treatment. Cohen's *d* ranges from 0 to 1, with higher values indicating a stronger

treatment effect. A value of 0.2, which is considered a small treatment effect, means that approximately 1% of the variance in the outcome can be attributed to the treatment. A medium effect size, d = 0.5, means that approximately 6% of the variance in the outcome can be attributed to the treatment. A large effect size, d = 0.8, means that about 14% of the variance in the outcome can be attributed to the treatment.

Finally, the analysis of child welfare outcomes is complicated by the fact that multiple children may have the same parent. In effect, there are two levels of analysis: parent and child. This is referred to as "nested data," that is, children are nested within mothers. The difficulty in analyzing nested data is that outcomes for children within a particular family are likely more similar than outcomes for children from different families. A basic assumption of many commonly used analytical techniques is that all subjects must be independent, that an outcome for one subject has no bearing on the outcome for other subjects in the dataset. This assumption is violated with nested data, which can result in biased significance tests. We used Linear Mixed Modeling in SPSS v14 to adjust the error terms for all of our child welfare outcome estimates in an effort to reduce the bias introduced by nested data.

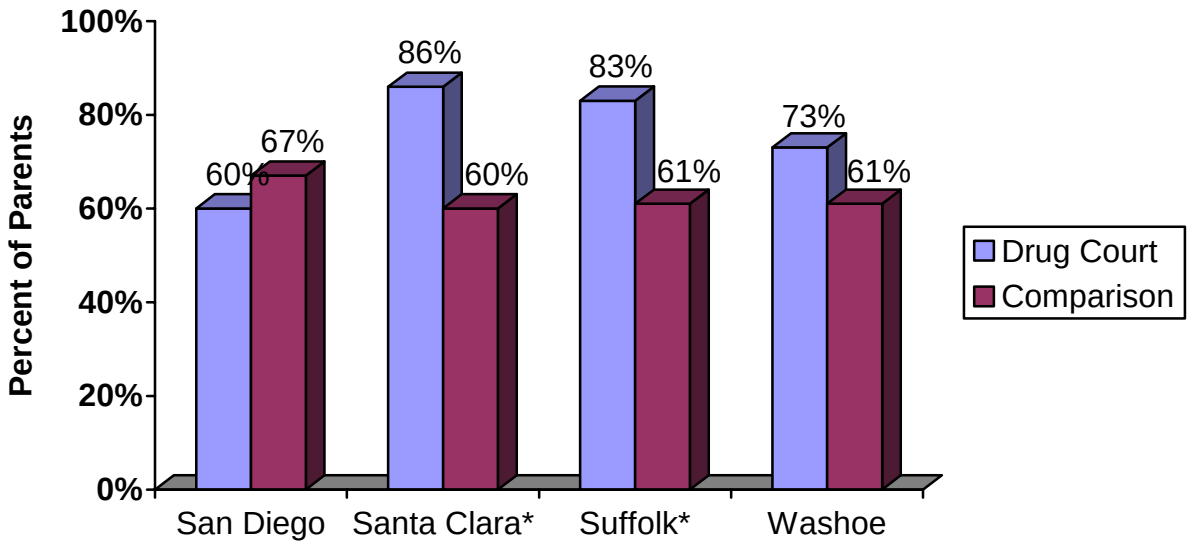
For operational definitions of all outcome variables, please see Appendix C, and for more detailed statistical results, see Appendix D. Appendix E presents data for San Diego separating out SARMS-only clients from drug court clients. The San Diego results below include data for all San Diego clients, weighting the SARMS and DDC samples to reflect their prevalence in the overall system (90% SARMS and 10% DDC).

Treatment Outcomes

Are FTDC System Mothers More Likely to Enter Treatment Than Comparison Mothers and Do They Enter Treatment More Quickly?

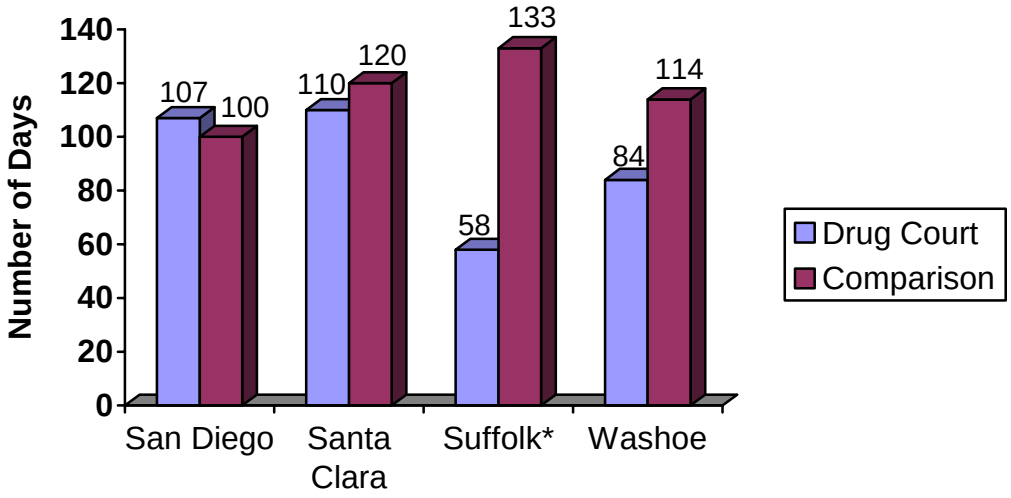
We measured both the likelihood of treatment entry (defined as having at least one treatment entry during the case) as well as the time to treatment entry (defined as the number of days from petition to treatment entry) for all cases in the study. As displayed in Figure 2, at two of the four study sites the FTDC mothers were significantly more likely to enter treatment than the comparison mothers. In addition, at one of the four study sites FTDC mothers entered treatment significantly sooner than comparison mothers. When the effects were pooled across the four sites, overall, FTDC mothers were significantly more likely to enter treatment than comparison mothers (pooled $t=-4.6$, $p<.001$) and they also entered treatment significantly faster than comparison mothers (pooled $t=2.4$, $p<.05$). The pooled effect size was relatively small (d = 0.2), suggesting that, averaged across the four sites, FTDC had a small influence on treatment entry and time to treatment.

Figure 2. Percent of Mothers with at Least One Treatment Entry



* Statistically significant at p<.001.

Figure 3. Mean Days to Treatment Entry

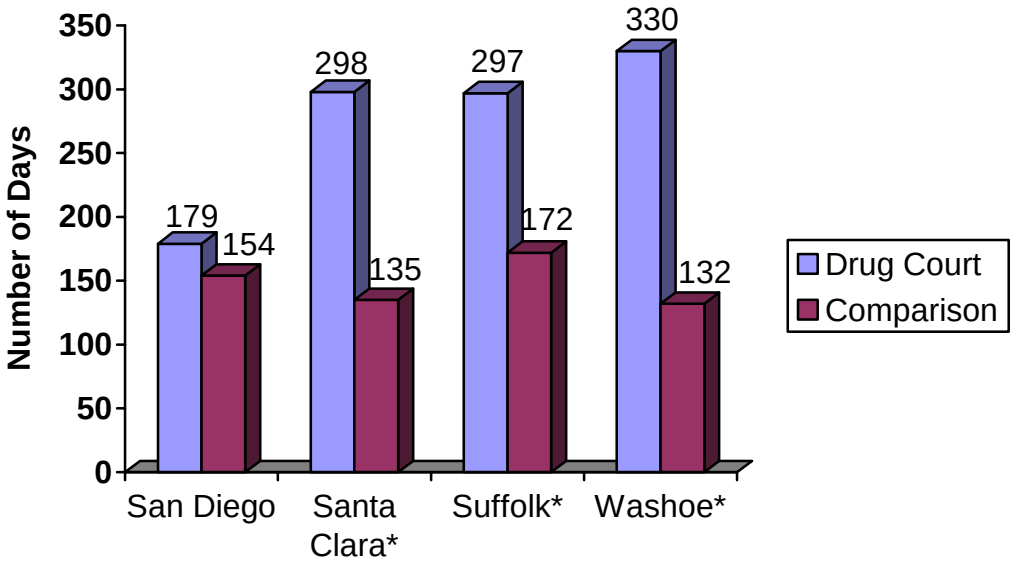


* Statistically significant at p<.001.

DO FTDC SYSTEM MOTHERS SPEND MORE TIME IN TREATMENT DURING THEIR CASE THAN COMPARISON MOTHERS?

We measured total, non-overlapping treatment days during the case for all mothers (mothers who did not enter treatment were recorded as having '0' days in treatment). As displayed in Figure 4, at three of the four sites, the FTDC mothers spent significantly more time in treatment during their case than the comparison mothers. Not surprisingly, when the effects were pooled across the four study sites, FTDC mothers spent significantly more time in treatment than comparison mothers (pooled t=-9.0, p<.001). FTDC appears to have had moderate effects on time spent in treatment (d = 0.4).

Figure 4. Days Spent in Treatment

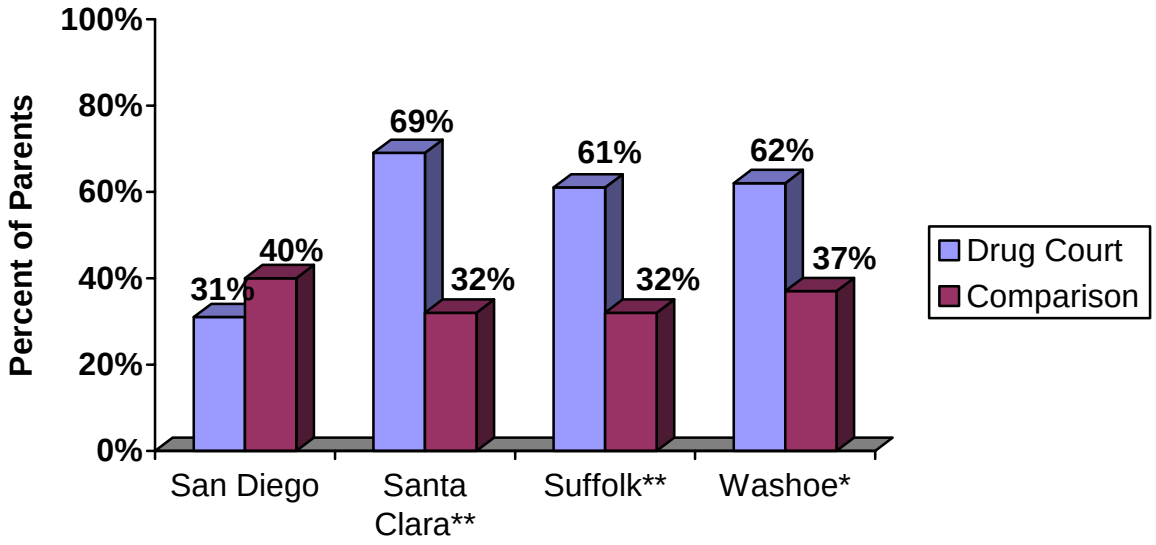


* Statistically significant at p<.001.

ARE FTDC SYSTEM MOTHERS MORE LIKELY THAN COMPARISON MOTHERS TO COMPLETE TREATMENT?

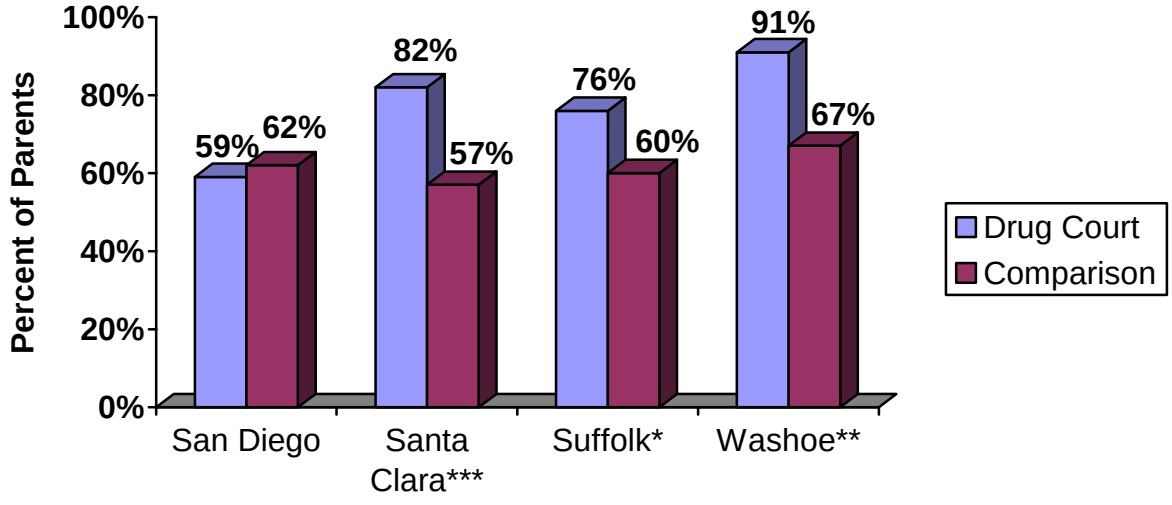
We measured whether mothers completed at least one treatment episode during their case, both for all mothers in the study (those who never entered treatment were coded as not completing treatment) and just for those mothers who entered treatment (those mothers who did not enter treatment were excluded from this calculation). At three sites, FTDC mothers were significantly more likely than comparison mothers to complete at least one treatment. When results were pooled across sites, FTDC mothers were more likely to complete treatment than comparison mothers (for all mothers, pooled t=-5.9, p<.001; for just mothers entering treatment, pooled t=-3.6, p<.001). FTDC had a small effect on treatment completion (all mothers d = 0.3, mothers who entered treatment d = 0.2).

Figure 5. Percent of Mothers Completing At Least One Treatment (All Mothers)



*Statistically significant at p<.01. **Statistically significant at p<.001.

Figure 6. Percent of Mothers Completing at Least One Treatment (Mothers Entering Treatment Only)



*Statistically significant at p<.01. **Statistically significant at p<.001.

Child Welfare Case Experiences

DO FTDC SYSTEM CHILDREN RECEIVE MORE SERVICES THAN COMPARISON CHILDREN?

Table 4 displays the average number of services provided to children. At one site (San Diego), children in the FTDC sample received significantly more services than children in the comparison sample, although the actual difference between the two groups was very small. Across all sites and samples, children received around 1 or 2 services during their cases. Pooling the effects across site resulted in no significant differences in the number of services received by FTDC or comparison children.

Table 4. Number of Children's Services

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Mean	1.4	1.2	1.3	1.2	0.5	0.5	1.7	1.7
n	788	475	199	1,132	259	491	148	226
F	**6.2***		3.6		0.03		0.5	

*Significant at p<.05.

DO FTDC SYSTEM CHILDREN HAVE FEWER CHANGES IN LIVING SITUATIONS, SPEND LESS TIME IN OUT-OF-HOME PLACEMENTS, AND SPEND MORE TIME WITH PARENTS AND KIN THAN COMPARISON CHILDREN?

Data were collected to measure the total number of living situation changes each child experienced during the case along with the number of days (and percent of case) spent with parents or in out-of-home placements (both kinship and non-kinship placements).

Table 5 displays the results for the four study sites. In one of the four sites (Santa Clara), children of FTDC mothers experienced significantly more living situation changes than comparison children, even after controlling for length of case. While there were no significant differences between FTDC and comparison children on this variable at the remaining three sites, when the effects were pooled across the four sites, FTDC children did have significantly more living situation changes than comparison children (pooled t=-3.2, p<.01). Despite statistical significance, the pooled effect of FTDC on living situation changes was very small (d = 0.1), and therefore this may not be a practically significant finding.

Because children tended to have multiple living situations and to cycle in-and-out of parental care, we report here the time spent with parents as well as the time spent in out-of-home care. At two of the four sites (Santa Clara and Washoe), FTDC children spent significantly more days (and a higher percentage of their cases) in parental care than did comparison children; similarly, when the effects across the four sites were pooled, FTDC children spent a greater percentage of the

case, and more absolute days with their parents than comparison children (mean days, pooled t=-8.0, p<.001; percent of case, pooled t=-5.3, p<.001). Overall, FTDC had a small effect on the number of days children spent in their parents' care (d = 0.3), and a somewhat smaller effect on the proportion of the case spent with parents (d = 0.2).

Not surprisingly, at these same two sites, FTDC children spent significantly fewer days (and a smaller percentage of their cases) in any out-of-home placements (kin or non-kin), and when effects were pooled across the four sites FTDC children overall spent significantly less time in out-of-home placements (number of days, pooled t=4.9, p<.001; percent of case, pooled t=5.9, p<.001). The pooled treatment effect of FTDC on out-of-home placements was small (d = 0.2).

There were no significant differences at the four sites (or overall using pooled effects) for the number of days or percent of case spent in kinship placements. At one of the four sites (Washoe), FTDC children spent significantly less time in non-kinship out-of-home placements; however, there were no significant differences between FTDC and comparison children when effects were pooled across the four sites.

Table 5. Children's Living Situations During the Case

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Number of Living Situations during the case (controlling for length of case)								
Mean	3.3	3.3	4.0	3.4	1.9	1.9	3.3	3.2
n	809	477	201	1,142	262	497	166	245
F	0.16		**16.3*** **		0.1		0.2	
Days spent in parental care								
Mean	150	143	207	128	284	269	286	90
n	788	456	174	1,100	262	495	164	244
F	0.2		**18.4*** **		0.3		**105.6*** **	
Percent of case spent in parental care								
%	26%	28%	31%	23%	46%	47%	50%	20%
n	788	456	174	1,100	262	495	164	244
F	0.6		**5.9***		0.1		**73.3*** **	
Days spent in any out-of-home placements								
Mean	477	477	437	504	312	310	301	466
n	817	457	194	1112	262	495	164	244
F	0		**8.1** **		0		**35.7*** **	

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent of case spent in any out-of-home placements								
%	72%	71%	65%	76%	54%	52%	51%	80%
n	810	457	194	1,111	262	495	164	244
F	0.1		**13.5*****		0.2		**68.7*****	
Days spent in kinship care placements								
Mean	252	244	247	287	198	228	102	129
n	819	459	198	1,115	262	495	164	245
F	0.1		2.3		1.1		1.2	
Percent of case spent in kinship care placements								
%	39%	37%	37%	43%	36%	39%	17%	23%
n	817	459	198	1,115	262	495	164	245
F	0.4		2.7		0.4		1.6	
Days spent in non-kin placements								
Mean	256	232	190	218	114	82	199	336
n	824	463	194	1,112	262	496	165	245
t-value	0.1		1.3		2.0		**18.8*****	
Percent of case spent in non-kin placements								
%	33%	34%	28%	33%	18%	14%	33%	58%
n	816	463	194	1,111	262	496	165	245
F	0.1		2.2		1.9		**26.1*****	

* Statistically significant at p<.05. **Statistically significant at p<.01. ***Statistically significant at p<.001.

Child Welfare Case Outcomes

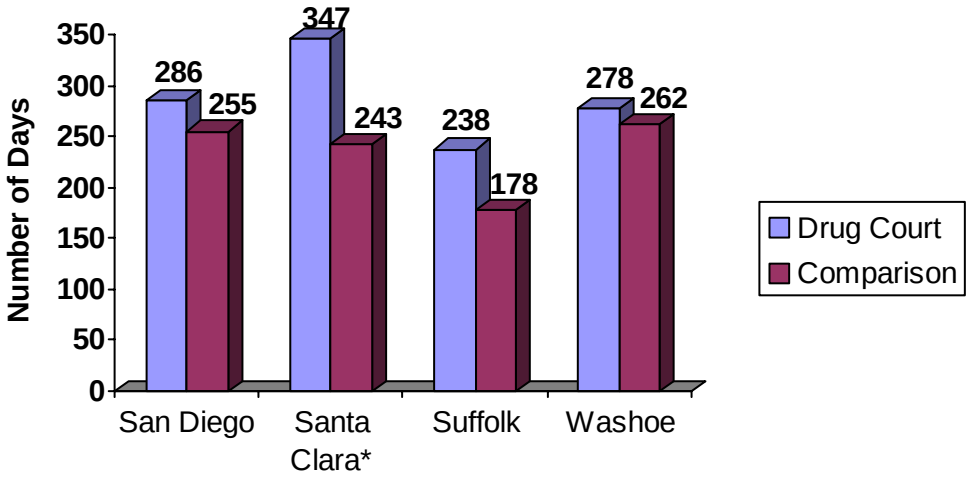
Only cases that had reached permanency decisions were included in the analyses of child welfare case outcomes described below. It is worth noting that approximately one-fourth (24%) of the cases in the study had not reached permanency within our two-year data collection window, and therefore were, of necessity, excluded from the analyses of child welfare case outcomes. The percentage of cases that had reached permanency within two years varied greatly by site: just 12% of Santa Clara and 13% of Washoe cases had not reached permanency within two years, while 20% of San Diego and 57% of Suffolk cases had not yet reached permanency.

DO FTDC SYSTEM CASES REACH PERMANENT PLACEMENT FASTER THAN COMPARISON CASES?

We measured time to permanent placement as the number of days from petition

to the date the child was placed in the permanent home (those children who were never removed from the home were excluded from this analysis. As illustrated in Table 6, at one site (Santa Clara), it took significantly longer for children of FTDC mothers to reach permanent placement than children of comparison mothers. The remaining three sites exhibited the same trend (as illustrated in Figure 7), though the results did not reach significance. However, when the effects were pooled across sites, it took significantly longer for FTDC children to reach permanent placement than comparison children. Not surprisingly, the pooled effect of FTDC on time to permanent placement was small (d = 0.2).

Figure 7. Time to Permanent Placement



*Statistically significant at p<.001.

We also investigated whether the time to permanent placement varied based on the type of permanent placement. At three of the four sites, FTDC cases that resulted in reunifications took significantly longer to reach that permanent placement than did cases that resulted in terminations of parental rights or some other, non-reunification, permanency outcome (at the fourth site, this analysis was not possible due to the extremely small number of cases that had a non-reunification permanency decision). This suggests that FTDCs may be moving quickly to find permanent solutions for children for whom reunification is not an option, and are taking more time to ensure that mothers who will reunify are ready to do so.

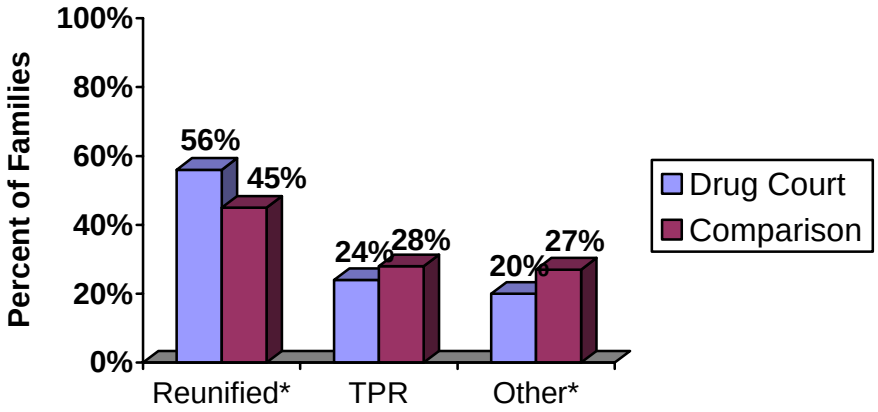
DO FTDC SYSTEM CASES RESULT IN MORE PARENT-CHILD REUNIFICATIONS AND FEWER TERMINATIONS OF PARENTAL RIGHTS?

At three of the four study sites, children of FTDC mothers were significantly more likely to be reunified than children of comparison mothers, and at two sites, children of FTDC mothers were significantly less likely to have terminations of parental rights. At three sites, children of FTDC mothers were significantly less likely than comparison children to have another type of permanency outcome, such as guardianship or long-term foster care.

Not surprisingly, when the permanency effects were pooled across the four sites, children of FTDC children were more likely to be reunified and less likely to have terminations of parental rights or other types of permanency outcomes ($p<.001$ for all analyses). These pooled treatment effects indicated a small effect, on average, of FTDC services on reunification and parental rights terminations ($d = 0.3$).

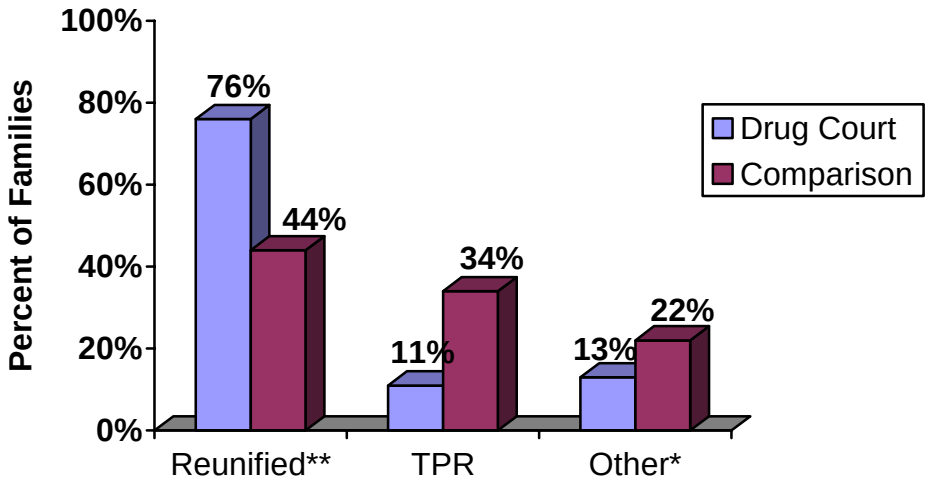
It is worth noting that for Suffolk County, more than half (57%) of the study cases had not reached permanency and therefore are not included in these analyses, so for this site it is difficult to draw conclusions about the differences in permanency outcomes for FTDC versus comparison cases. Furthermore, because the Suffolk court works only with parents with neglect cases, many more children at this site are never removed from their homes compared to the other three study sites. The reunification data above combines those cases in which children were reunified with those cases in which the children remained (e.g., were never removed) with their mothers. When we examined data just for those children who were removed and then reunified at the Suffolk site, we saw, while not reaching statistical significance, that the trend was in the expected direction: more FTDC children were returned home than comparison children.

Figure 8. San Diego Permanency Outcomes



*Statistically significant at $p<.05$.

Figure 9. Santa Clara Permanency Outcomes



*Statistically significant at p<.05. **Statistically significant at p<.001.

Figure 10. Suffolk Permanency Outcomes

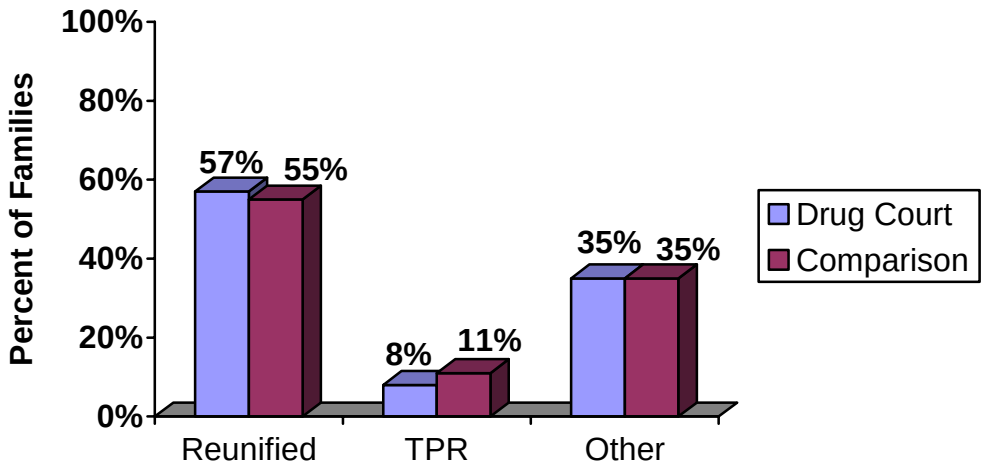
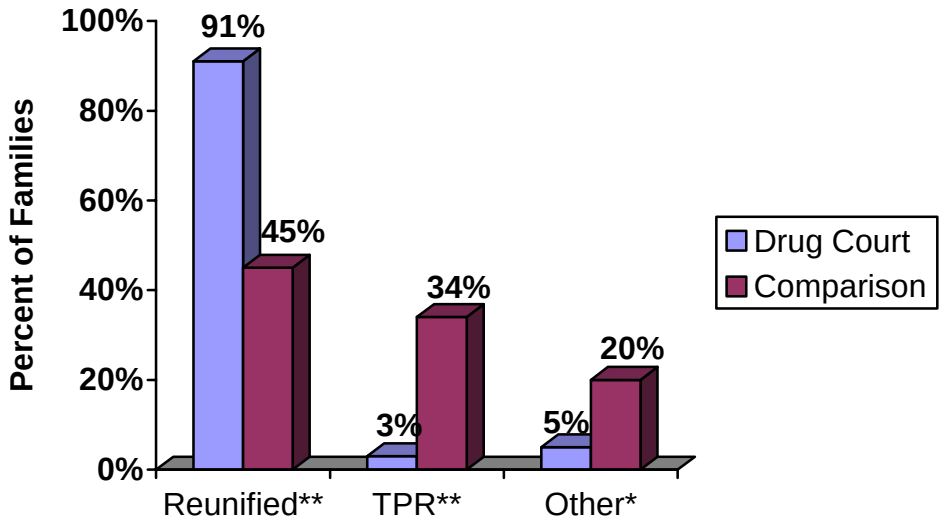


Figure 11. Washoe Permanency Outcomes



*Statistically significant at p<.01. **Statistically significant at p<.001.

Child Welfare Recidivism

ARE FTDC SYSTEM MOTHERS LESS LIKELY THAN COMPARISON MOTHERS TO HAVE SUBSEQUENT CHILD WELFARE INVOLVEMENT?

We collected information on subsequent child welfare involvement for both the mothers and children in our study cases. Table 6 presents a variety of measures of child welfare recidivism for ***mothers***. These recidivism measures included whether the parent received a second petition on her original case as well as whether she had subsequent substantiated cps referrals, petitions, out-of-home placements, or terminations of parental rights. Finally, we also recorded how many pregnant mothers gave birth to drug-exposed infants.

Overall, recidivism rates for mothers across all sites and groups were low, and we found few significant differences between the FTDC and comparison samples. This is likely due, at least in part, to the short study window; we collected two years of data (from date of original petition) for each family, and therefore there simply was not adequate time to capture recidivism. Indeed, 61% of the original cases remained open even after two years, making it impossible to gather recidivism information for those families. Furthermore, interpreting the meaning of recidivism data can be difficult given that FTDC mothers may be under closer scrutiny than comparison group mothers, and therefore may be more likely to come to the attention of child welfare workers again, resulting in higher, not lower, recidivism rates. With the exception of one recidivism measure for one site (new CPS petitions in Suffolk), however, we did not find that FTDC mothers had higher recidivism rates than comparison mothers; rather, we found no differences between the groups. Not surprisingly, when the recidivism effects were pooled across all sites, there were no significant

differences between FTDC and comparison samples. In two sites (Santa Clara and Washoe), however, FTDC mothers appeared to have fewer drug exposed infants; while the absolute number of infants is small, this could represent a significant cost-savings for those counties.

We also examined recidivism at the child level. We found very little recidivism for children involved in the study cases (31 new petitions). This suggests that these children, for the most part, did not re-enter the child welfare system during our study window. Although the sample size is quite small, it is also important to note that children who did re-enter the system were much more likely to be those children who came from families that experienced a TPR: eight children (26% of those with recidivism) came from families in which the original permanency decision was a termination of parental rights. Of those without recidivism, only 9% had had an original TPR. Further, mothers who had a subsequent petition (most likely with a new child or infant) were much more likely to have had a TPR on their original case compared to those who did not recidivate. This suggests that recidivism is more likely to occur for both children and mothers when the original case is not successfully resolved and a decision to terminate parental rights is made.

Table 6. Subsequent Child Welfare Involvement

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent with second petition on original case								
%	23%	16%	9%	12%	1%	1%	2%	1%
n	438	205	100	553	117	239	84	127
F	**5.5***		2.1		0.1		0.4	
Percent with a new substantiated cps referral after the start of the original case								
%	23%	20%	17%	18%	1%	2%	16%	17%
n	436	203	100	542	116	237	83	152
F	0.3		0.3		1.4		0	
Percent with a new cps petition after the original case closed								
%	7%	9%	2%	6%	5%	0	2%	2%
n	187	73	41	209	29	96	57	48
F	0.5		2.7		**4.3***		0	
Percent with subsequent out-of-home placements after the original case closed								
%	8%	11%	2%	6%	0	3%	2%	2%
n	187	73	41	208	29	96	57	48
F	0.7		2.7		2.4		0	
Percent with subsequent TPR after the original case closed								
%	1%	0	3%	2%	0	0	0	0
n	176	69	41	205	29	96	58	49
F	1.6		2.6		0		0	
% with a new drug-exposed baby after the start of the original case (pregnant mothers only)								
%	17%	18%	6%	30%	48%	29%	7%	35%
n	71	29	16	76	6	7	14	19
F	0		**9.8****		0.4		**4.4***	

*Significant at p<.05. **Significant at p<.01.

Court Outcomes

ARE FTDC SYSTEM MOTHERS MORE LIKELY TO COMPLY WITH THEIR CHILD WELFARE SERVICE PLANS THAN COMPARISON MOTHERS?

We collected information on the number of contested hearings as well as indications of noncompliance with case plans, as measured by court order modifications due to a variety of factors (most often treatment noncompliance or noncompliance with visitations). As illustrated in Table 7, for San Diego, FTDC mothers were significantly less likely than comparison mothers to have court order modifications; the remaining three sites

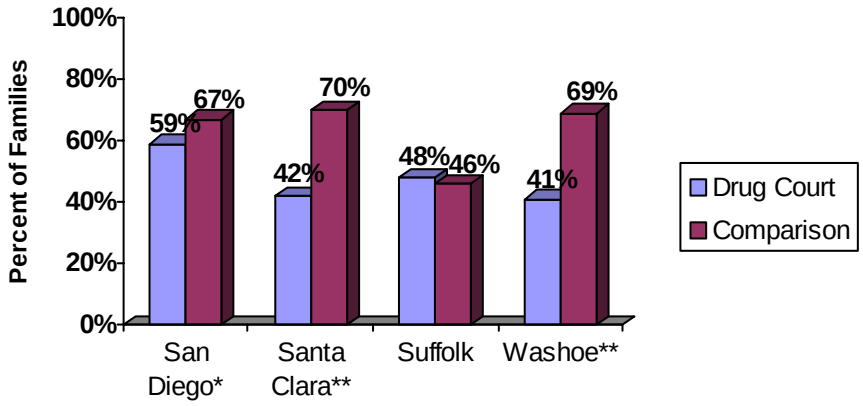
did not exhibit this pattern. However, at three of the four sites, FTDC mothers were significantly less likely than comparison mothers to have indications of noncompliance in their court record. Not surprisingly, when the effects were pooled across sites, there were no significant differences between FTDC and comparison mothers in the percentage of contested hearings, but FTDC clients were significantly less likely than comparison mothers to have indications of noncompliance (pooled t=4.7, p<.001). The pooled effect of FTDC on noncompliance was small (d = 0.3).

Table 7. Contested Hearings & Court Order Compliance

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent of hearings that were contested								
Mean	27%	39%	33%	39%	95%	98%	17%	17%
n	411	166	89	432	117	239	82	125
F	**8.2****	1.7	2.9	0				
Percent of cases with indications of noncompliant behavior								
%	59%	67%	42%	70%	48%	46%	41%	69%
n	433	203	92	533	117	239	83	127
F	**4.8***		**52.3*****		0.2		**18.1*****	

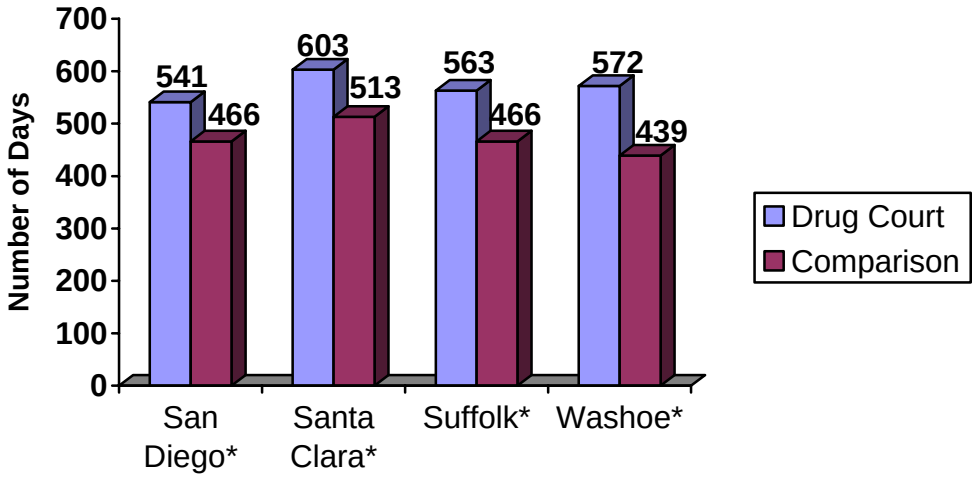
*Significant at p<.05. **Significant at p<.01. ***Significant at p<.001.

Figure 12. Indications of Noncompliance



*Significant at p<.01. **Significant at p<.001.

Figure 13. Time to Court Case Closure



*Significant at p<.001.

DO FTDC SYSTEM CASES REACH CASE CLOSURE FASTER THAN COMPARISON CASES?

At the time of data collection, 41% of FTDC cases and 37% of comparison cases had reached court case closure (San Diego FTDC 39%, comparison 34%; Santa Clara FTDC 41%, comparison 37%; Suffolk FTDC 25%, comparison 40%; Washoe FTDC 69%, comparison 39%). Figure 13 displays the average time to case closure for FTDC and comparison cases; at all sites, FTDC cases were significantly longer than comparison cases. Not surprisingly, the cross-site effect size was significant (pooled t=-7.6, p<.001). The pooled effect of FTDC on time to case closure was moderate (*d* = 0.6). However, it is likely that the length of cases reported here is an underestimate of their actual length, and therefore, this result should be interpreted with caution.

It also is worth noting that court cases (for both the FTDC and comparison samples) were markedly longer than the time to permanency. Indeed, court cases continued on average for 6-11 months after children were placed in their permanent placement. This could be due to several factors. First, we measured time to permanent placement, not time to permanency hearings or orders; permanent placement could, and often did, happen earlier than an official permanency hearing or order.[7] Court cases would of necessity remain open at least until the issuance of the official permanency order. Second, courts frequently keep cases open after permanency has been achieved in order to monitor the case and to provide ongoing services to the family as necessary.

[7] We did not gather data on permanency hearings or orders due to site variations in whether, how, and when such events took place. For example, a permanency hearing can be scheduled and then continued to a later date. Further, courts often did not file a formal permanency order in cases of family reunification. Therefore, for the purposes of this study we decided to approach permanency from the vantage point of the child: the date the child entered the home that was recorded by the child welfare system as his/her final, and permanent, placement.

CHAPTER 4: PARENT PSYCHOSOCIAL CHARACTERISTICS AND PERCEPTIONS OF THEIR DRUG COURT EXPERIENCES

In addition to collecting a wide range of administrative data, this study included an interview component with a subset of FTDC mothers from the larger administrative sample. Including an interview component in the study allowed the evaluation team to gather information on mothers' psychosocial characteristics and perceptions of the services they were receiving, information that is not available through administrative records. Having this in-depth information about mothers receiving FTDC services is interesting in its own right, but even more importantly, can be useful for investigating questions such as for whom and why drug courts work. In this chapter we present some descriptive information about mothers' psychosocial characteristics and experiences, and in the following chapter we use this information to begin to answer questions about how, for whom, and why drug courts work.

Interview Sample Description

As described in the methodology chapter, a subset of mothers at each site was recruited to participate in the interview component of the study. Consistent with the remainder of this report, in this chapter we present data on mothers only (n=136). Because the interview sample size within each site varied, and in some cases was quite small (67 mothers from San Diego, 28 from Santa Clara, 24 from Suffolk, and 17 from Washoe), we have collapsed the interview data across sites. For a selection of interview data broken down by site (ancillary service need and receipt), please see Appendix F.

Overall, the demographic characteristics of the interview sub-sample mirror the larger administrative sample. Fewer than half the mothers (44%, or 59) were Caucasian, 28% were Hispanic, and 8% were African American. They were on average 32 years old and had an average of 3 children. Most (81%, or 108 mothers) were single, divorced, or separated. A majority (69%, or 92 mothers) had a high school degree or less, and 31% (43 mothers) were employed. Half (66 mothers) had no health insurance and almost one-third (39 mothers) had a chronic medical condition. In the 90 days prior to their baseline interview, 43% (57) had received food stamps, 22% (29) had received WIC, 21% (28) had received TANF, 8% (10) had received disability payments, and 6% (8) had received social security payments.

Parent Psychosocial Characteristics

The interview instrument included several standardized scales to measure a variety of parent psychosocial characteristics, including substance use history, social support, treatment motivation, psychiatric status, perceptions of control, and stress.

SUBSTANCE USE HISTORY

Substance use history was measured using the ASI Lite (McLellan, Kishner, Metzger & Peters, 1992). Below we present data on parental drug use immediately prior to the start of the case as well as lifetime drug use history. Consistent with the data from the larger administrative sample, as illustrated in Table 8, amphetamines (primarily methamphetamines) were the most common drugs used among interview respondents.

Table 8. Drugs Most Frequently Used in 30 Days Before the Start of the Case

Drug	% (n) of Mothers
No Drug Use	16% (22)
Alcohol	9% (12)
Heroin / Opiates	5% (6)
Barbiturates / Sedatives	1% (1)
Cocaine / Crack	5% (7)
Amphetamines[1]	35% (46)
Cannabis	16% (21)
Polydrug[2]	14% (18)

[1] Three of the four study sites were located on the West Coast, thus accounting for the high use of amphetamines.

[2] Polydrug = participant indicated using two or more drugs with the same frequency in the 30 days before the start of his/her case.

Approximately one-third of the interview sample reported spending money on alcohol in the 30 days prior to the start of the case, and those mothers spent about $100 on average (with a range of $3 to $550), as illustrated in Table 9. Just under half the sample reported spending money on drugs in the 30 days prior to the start of the case, and those mothers spent an average of $649 (with a range of $20 to $9,000). A majority of mothers (63%) reported that in the month before the start of their case they had at least one day on which they experienced problems due to their drug use (these mothers reported problems on an average of 19 days in the month prior to the start of their case). A smaller number of mothers reported problems due to alcohol abuse on one or more days in the month prior to the start of their case.

Table 9. Money Spent, Days Experienced Alcohol and Drug Problems, and Days Spent in Alcohol and Drug Treatment in 30 Days Before Start of Case

In the 30 days before the start of the case:	% who reported "0" (n)	Average[1] (n)
How much money spent on alcohol (N=132)	68% (90)	$98 (42)
How much money spent on drugs (N=132)	55% (72)	$649 (60)
How many days experienced alcohol problems (N=132)	77% (102)	12 (30)
How many days experienced drug problems (N=132)	37% (49)	19 (83)

[1] Means do not include mothers who reported "0" (e.g., spent $0 on alcohol).

Table 10 displays the drugs used by mothers over the course of their lifetimes. Consistent with mothers' reports of the drugs used in the month prior to the start of their cases, amphetamines were the most commonly abused drugs; 61% of the interview sample reported abusing methamphetamine for at least 1 year. Cannabis, alcohol, and cocaine were the other most popular drugs, with 51%, 42%, and 28% of mothers, respectively, reporting 1 or more years of abuse.

Table 10. Lifetime Drug Use

	Lifetime Use (N=132)	
Drug	**% Who Used (n)**	**Mean[1] # Years Used (n)**
Alcohol	42% (56)	8 (56)
Heroin	10% (13)	6 (13)
Other Opiates	9% (12)	4 (12)
Barbiturates	7% (9)	4 (9)
Other Sedatives	10% (13)	4 (13)
Cocaine / Crack	28% (37)	5 (37)
Amphetamines[2]	61% (81)	8 (81)
Cannabis	51% (67)	9 (67)
Hallucinogens	14% (19)	3 (19)
Inhalants	4% (5)	3 (5)
Other Drugs	5% (6)	4 (6)

[1] Means do not include mothers who did not report use.

[2] Three of the four study sites were located on the West Coast, thus accounting for the high use of amphetamines.

SOCIAL SUPPORT

The interview contained a standardized scale to measure social support (Interpersonal Support Evaluation List, Cohen et al., 1985) along with items developed for this study to measure social support for recovery. Mothers reported high levels of social support at baseline and at subsequent interviews, with over 90% of mothers agreeing that their friends and family wanted them to stay sober and were helping them in their recovery. It is worth noting that the baseline interviews took place, on average, two months after the start of mothers' cases, and thus, these ratings may not be a true indication of mothers' social support at the start of their cases. The high social support ratings could be due, at least in part, to the fact that these mothers, as a result of their case and involvement in drug court, were now connected with services that increased their feelings of social support.

TREATMENT MOTIVATION

The interview instrument included the TCU Treatment Motivation Scale (TCU Institute of Behavioral Research, 2002), which consists of four subscales: desire for help (e.g. "you need help dealing with your drug use"), treatment readiness (e.g. "you want to be in a drug treatment program now"), external pressure (e.g. "you have family members who want you in treatment"), and problem recognition (e.g. "your drug use is causing problems with thinking or doing your work"). Table 11 lists the baseline subscores; as illustrated in the table, most mothers exhibited strong motivation for treatment.

Table 11. Treatment Motivation

Subscale	Strongly Agree % (*n*)	Agree % (*n*)	Neither % (*n*)	Disagree % (*n*)	Strongly Disagree % (*n*)
Desire for Help (N=130)	37% (48)	37% (48)	23% (30)	3% (4)	0
Treatment Readiness (N=117)	20% (23)	55% (64)	20% (23)	4% (5)	2% (2)
External Pressure (N=130)	12% (16)	39% (51)	40% (52)	9% (11)	0
Problem Recognition (N=128)	20% (26)	40% (51)	23% (29)	16% (20)	2% (2)

PSYCHIATRIC STATUS

Psychiatric status was measured using the ASI Lite Psychiatric subscale. Mothers reported a high degree of psychiatric problems, as illustrated in Figure 14. One quarter of the mothers interviewed reported experiencing serious depression in the past month and over 60% reported serious depression in their lifetimes. Nearly half of the mothers reported serious anxiety in the past 30 days, and 70% reported serious anxiety in their lifetimes.

Almost a quarter of the mothers had been in residential psychiatric treatment at some point in their lives, and a third reported receiving outpatient psychiatric treatment in their lives.

Figure 14. Mothers' Mental Health Issues: Past 30 Days and Lifetime

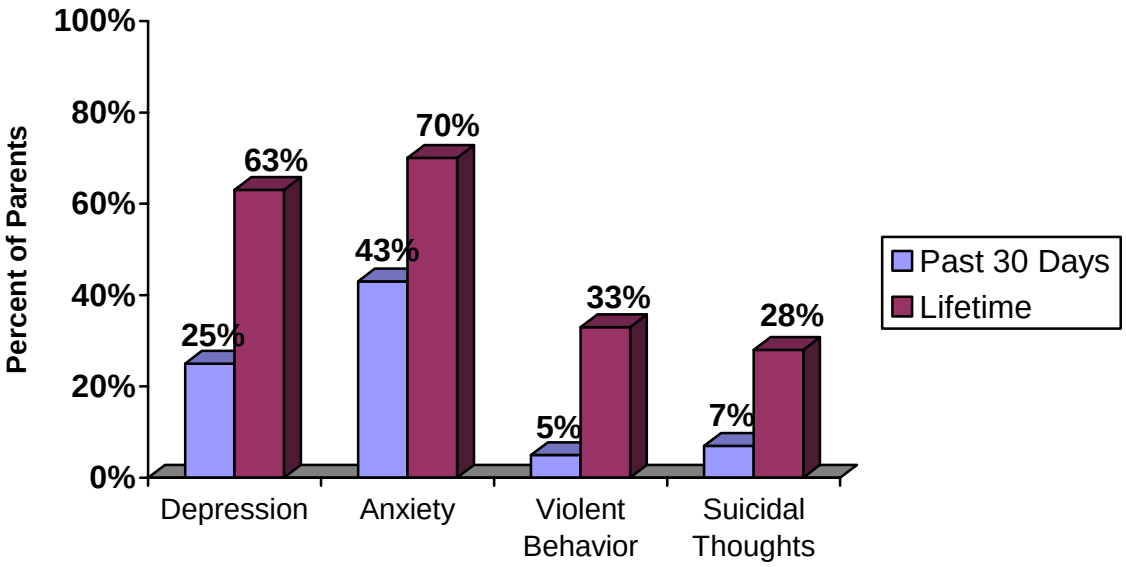


Table 12. Number of Times in Residential or Outpatient Mental Health Treatment During Lifetime

Item	Mean[1] (n)	% in Treatment (n)
Number of residential episodes (lifetime)	3.2 (21)	23% (93)
Number of outpatient episodes (lifetime)	5.3 (32)	34% (93)

[1] Means do not include mothers who did not report mental health treatment.

PARENTAL PERCEPTIONS OF CONTROL AND STRESS

Parental perceptions of control were measured using a modified version of the Family Empowerment Scale (Koren et. al., 1992), and parental stress was measured using the Perceived Stress Scale (Cohen et al., 1983). Mothers had strong feelings of control at baseline (over 80% of mothers felt they had control over events in their lives) and relatively low stress levels (only 24% of mothers agreed with statements indicating that they had stress in their lives). As with the measures of social support, it is worth noting that the baseline interview was conducted several months *after* the start of the child welfare case, and therefore, these scores could reflect mothers' states of mind while they were receiving services rather than prior to the receipt of services.

PARENTING SKILLS

The interview contained two subscales of the Adult Adolescent Parenting Index (AAPI, Bavolek et al., 1999). Table 13 displays mothers' baseline scores. This scale measures parents' attitudes about parenting. Higher scores on the empathy subscale indicate more positive parenting attitudes; lower scores on corporal punishment indicate less endorsement of corporal punishment as an appropriate discipline strategy.

Table 13. Mothers' Beliefs about Empathy and Corporal Punishment in Parenting

Subscale	Strongly Disagree % (n)	Disagree % (n)	Uncertain % (n)	Agree % (n)	Strongly Agree % (n)
Empathy (N=132)	0	0	10% (13)	71% (93)	20% (26)
Corporal Punishment (N=132)	24% (31)	58% (76)	17% (23)	2% (2)	0

Mothers' Experiences With FTDC Services

In this section, we report information about mothers' drug court experiences. Drawing from the larger administrative sample, we first present data about drug court dosage, including time spent in drug court, number of drug court hearings, and graduation rates. We then return to the interview data to explore mothers' receipt of needed ancillary services, their experiences with helping professionals, and their experiences with their children during their cases.

DRUG COURT PROCESSING

Table 14 displays administrative data on the time to drug court entry, the days spent in drug court, and the number of drug court hearings for each of the four study sites. The differences across sites can be explained in part by the different models used. For example, in San Diego, mothers do not enter drug court until after they have struggled in the Tier 1 program, and therefore it is not surprising that the time to drug court entry in San Diego is longer than the time to entry at the other sites. In Santa Clara and Washoe, where a more "traditional" FTDC is in place, it appears to take slightly more than 3 months to enter drug court after the initial child welfare petition. Further, in both of these courts, the average time spent in FTDC services is about one year—consistent with their program model. Interestingly, these two courts differ primarily in the number of FTDC appearances per month, with Santa Clara providing only about one per month compared to about two per month in the Washoe site.

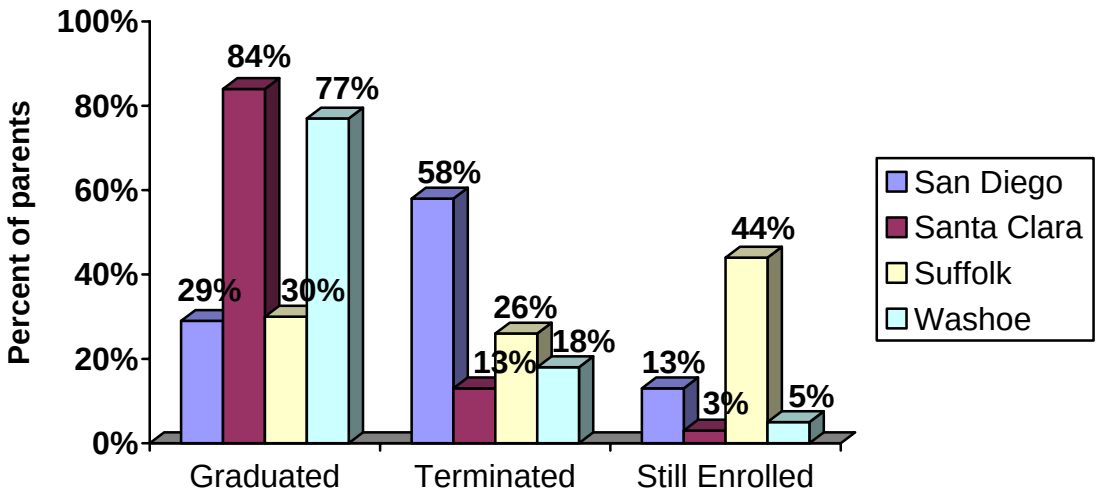
Table 14. Drug Court Processing

	San Diego	Santa Clara	Suffolk*	Washoe
Days to drug court entry				
Mean	227	102	NA*	105
n	95	100		84
Days spent in drug court				
Mean	209	355	NA*	353
n	75	97		78
Number of drug court appearances				
Mean	17 (approx. 2 per month)	15 (approx. 1 per month)	31 (approx. 2 per month)	25 (approx. 2 per month)
n	82	97	88	75

*Drug court start date was not collected in Suffolk County.

Figure 15 displays the graduation status at the time of data collection. While in Santa Clara over 80% of the drug court mothers had graduated at the time of data collection (and just over 10% were terminated and only a handful were still enrolled), in contrast, in Suffolk almost half the cases were still enrolled in drug court due to the longer average length of stay in the program. In San Diego, over half the mothers had been terminated from drug court; this high termination rate could be due to the fact that San Diego's drug court only enrolled mothers who were already struggling in the first tier of the county's two-tiered model.

Figure 15. Drug Court Graduation Rates



NUMBER AND TYPES OF SERVICES NEEDED AND RECEIVED

The interview instrument also asked mothers whether they needed a variety of ancillary services, and if so, whether they had received the services they needed. Below we report on mothers' need and receipt of services over the life of their cases. As illustrated in Table 15, the most common services that mothers reported needing included substance abuse treatment, parenting classes, mental health services, transportation, financial assistance, and housing. Table 15 also illustrates what percentage of mothers received the service. Overall, most mothers reported receiving the services they needed; the services that mothers were *least* likely to receive included housing, help getting health insurance, help with childcare, employment assistance, financial assistance, and marital counseling.

Table 15. Need for and Receipt of Various Ancillary Services

Service	% needed during their case (*n*)	% received (*n*)
Substance abuse treatment services	76% (102)	73% (99)
Parenting classes	75% (101)	70% (94)
Mental health services	69% (52)	55% (41)
Help with transportation	68% (92)	57% (77)
Financial assistance	59% (80)	31% (40)
Help with housing	55% (74)	30% (42)
Help getting health insurance	52% (70)	21% (29)
Help for children (e.g., counseling)	51% (69)	42% (56)
Medical services / medication	48% (65)	38% (52)
Substance abuse assessment	47% (63)	46% (62)
Childcare	33% (45)	22% (30)
Help finding employment	26% (35)	13% (18)
Domestic violence services	26% (35)	19% (26)
Relationship or marital counseling	22% (30)	11% (15)

Those mothers who did receive services were asked who, if anyone, helped them find the needed services, as illustrated in Table 16. CPS case workers and treatment providers were frequently the professionals who helped obtain services, though mothers also frequently reported that someone other than a member of the drug court team, or even no one at all, helped them obtain the services they needed.

Table 16. Professionals Who Helped Obtain Ancillary Services

	Who helped obtain the service? % (*n*)						
Service	**Drug Court Social Worker**	**Drug Court Judge**	**Attorney**	**CPS Case-worker**	**Treatment Provider**	**Other**	**No one**
Help with transportation	12% (13)	8% (9)	0	41% (44)	9% (10)	27% (29)	2% (2)
Help with housing	9% (5)	8% (4)	2% (1)	17% (9)	25% (13)	25% (13)	15% (8)
Help getting health insurance	3% (1)	0	0	22% (7)	19% (6)	31% (10)	25% (8)
Help for children (e.g., counseling)	7% (5)	7% (5)	4% (3)	44% (31)	6% (4)	20% (14)	11% (8)
Parenting classes	22% (27)	10% (12)	1% (1)	30% (37)	23% (29)	10% (13)	4% (5)
Childcare	6% (2)	3% (1)	0	38% (12)	6% (2)	38% (12)	9% (3)
Help finding employment	5% (1)	5% (1)	0	0	26% (5)	42% (8)	21% (4)
Financial assistance	2% (1)	2% (1)	2% (1)	21% (10)	13% (6)	35% (17)	25% (12)
Mental health services	4% (2)	2% (1)	0	37% (18)	35% (17)	14% (7)	8% (4)
Substance abuse assessment	38% (29)	14% (11)	0	13% (10)	29% (22)	5% (4)	1% (1)
Substance abuse treatment services	26% (43)	13% (22)	1% (1)	20% (33)	25% (40)	9% (14)	6% (10)
Domestic violence services	13% (5)	23% (9)	3% (1)	40% (16)	5% (2)	13% (5)	5% (2)
Medical services/medication	1% (1)	3% (2)	3% (2)	4% (3)	25% (17)	31% (21)	32% (22)
Relationship or marital counseling	13% (2)	6% (1)	0	38% (6)	25% (4)	19% (3)	0

Finally, mothers were asked to rate how helpful they found the services they received, as displayed in Table 17. Overall, mothers found services to be helpful; those services that were rated as helpful by the *fewest* number of mothers included employment services (37% rated this as not helpful), substance abuse assessments (30% rated this as not helpful), and marital counseling (22% rated this as not helpful).

Table 17. How Helpful Mothers Perceived Ancillary Services

	How helpful was the service? % (*n*)			
Service	**Not at all**	**A little**	**Very**	**Extremely**
Mental health services (N=19)	10% (4)	8% (3)	36% (14)	46% (18)
Substance abuse treatment services (N=39)	2% (2)	9% (9)	42% (41)	46% (45)
Childcare (N=31)	3% (1)	7% (2)	45% (14)	45% (14)
Help with transportation (N=59)	1% (1)	12% (9)	46% (35)	42% (32)
Medical services / medication (N=50)	2% (1)	14% (7)	44% (22)	40% (20)
Help for children (e.g., counseling) (N=56)	4% (2)	18% (10)	41% (23)	38% (21)
Help with housing (N=39)	5% (2)	18% (7)	41% (16)	36% (14)
Parenting classes (N=92)	3% (3)	5% (5)	55% (51)	36% (33)
Financial assistance (N=40)	3% (1)	15% (6)	50% (20)	33% (13)
Relationship or marital counseling (N=15)	7% (1)	20% (6)	40% (6)	33% (5)
Substance abuse assessment (N=61)	10% (6)	20% (12)	43% (26)	28% (17)
Domestic violence services (N=26)	8% (2)	12% (3)	54% (14)	27% (7)
Help getting health insurance (N=31)	7% (2)	10% (3)	65% (20)	19% (6)
Help finding employment (N=16)	6% (1)	31% (5)	44% (7)	19% (3)

FREQUENCY AND QUALITY OF INTERACTIONS WITH SYSTEM PLAYERS

Mothers were asked to report how frequently (in the past month) they participated in key drug court events and meetings, including court appearances, urinalyses, meetings with child welfare workers, meetings with attorneys, meetings with treatment counselors, and meetings with case managers. Mothers' reports collapsed across all interview time points are displayed below. Mothers' most frequent interactions were with their treatment providers (60% of mothers reported seeing their treatment counselors more than once per week), though many mothers also spoke with their CPS social worker several times a month or more.

Table 18. Frequency of Parent Meetings with Helping Professionals

In the past month, how often have you:	Never % (*n*)	Once % (*n*)	2-3 times % (*n*)	Once a week % (*n*)	< once a week % (*n*)
Appeared in court for this CPS case (N=134)	3% (4)	53% (71)	37% (50)	5% (7)	2% (2)
Had a urinalysis (N=135)	4% (5)	6% (8)	30% (41)	32% (43)	28% (38)
Met with or spoken to your CPS caseworker (N=135)	4% (6)	30% (40)	32% (43)	27% (37)	7% (9)
Met with or spoken to your attorney (N=135)	15% (20)	54% (73)	27% (37)	4% (5)	0
Met with or spoken with a substance abuse treatment counselor (N=135)	4% (6)	13% (17)	22% (29)	32% (43)	60% (40)
Met with or spoken with a case manager or someone besides your CPS caseworker who is helping you with your CPS plan (N=134)	20% (27)	16% (22)	39% (52)	19% (25)	6% (8)

The interview instrument also included a set of scales developed for this study to measure the quality of relationships with key system players (the judge, the CPS worker, the treatment provider, and the drug court case manager). The scales consisted of items asking the mothers whether they agreed the person cared about what happened to her, was knowledgeable about the case, helped the parent get what she needed, and explained what the parent needed to do to be successful in her case. Mothers' scores on these scales were stable across the interview time points; Table 19 presents mothers' baseline scores. Most mothers reported agreeing that they had high quality relationships with the professionals involved with their case, though 29% did not feel that they had a high quality relationship with their CPS social worker.

Table 19. Mothers' Agreement That They Had a High-Quality Relationship With Professionals Involved in Their Case

	Strongly Disagree % (*n*)	Dis-agree % (*n*)	Agree % (*n*)	Strongly Agree % (*n*)
High quality of relationship with judge (N=130)	2% (3)	16% (21)	45% (59)	36% (47)
High quality of relationship with CPS case worker (N=130)	9% (11)	20% (26)	49% (64)	22% (29)
High quality of relationship with treatment counselor (N=130)	3% (3)	5% (6)	54% (66)	39% (47)
High quality of relationship with drug court case manager (N=88)	4% (5)	11% (10)	64% (56)	19% (17)

Mothers' Experiences With Children

In addition to capturing information about mothers' psychosocial characteristics and drug court experiences, the interview instrument included questions about mothers' interactions with their children during their case, including questions about the frequency of visitation, how the mothers felt about their visits with their children, and mothers' perceptions of their children's well-being. The interviewers selected a target child (for those mothers with more than one child) as the focus of these interview questions.

VISITATION

Table 20 displays the frequency of visitation reported by mothers. Over 80% of mothers reported having four or more visits with their children in the past month, though just over one-quarter reported that their social workers canceled one or more visits and almost one-fifth reported missing one or more visits.

Table 20. Visitation With Children in the Past 30 Days

In the past 30 days:	0 times	1 time	2 or 3 times	4 or more times
How many visits were scheduled with your child? (N=114)	2% (2)	3% (3)	10% (11)	86% (98)
How many visits have you had with your child? (N=114)	2% (2)	2% (2)	14% (16)	83% (94)
How often have your visits been cancelled or rescheduled by your CPS worker (or whoever schedules your visits)? (N=113)	71% (80)	23% (26)	5% (6)	1% (1)
How often have you missed a scheduled visit with your child? (N=112)	81% (91)	18% (20)	1% (1)	0

The interview also included scales developed for this study to measure how mothers felt about their visitation and how they perceived their children to feel during the visitations. Table 21 displays mothers' scores on these scales. Overall, mothers felt positive themselves during the visit and believed that their children responded positively as well.

Table 21. Mothers' Feelings During Their Last Visit with Their Children

	Strongly Disagree % (n)	Disagree % (n)	Agree % (n)	Strongly Agree % (n)
Parent felt positive about herself during last visit. (N=114)	0	1% (1)	64% (73)	35% (40)
Parent thought that child responded positively during their last visit. (N=109)	0	5% (5)	62% (68)	33% (36)

In addition to asking about visitation, the interview asked mothers about their perceptions of their children's well-being. Mothers were asked whether they thought their children were receiving the services they needed, whether they thought their children were well cared for in the current living situation, and whether they thought their children were safe. The interview also included the Social Skills Rating Scale (Elliot et al., 1988), consisting of two subscales to measure children's positive social behavior and social problems.

As illustrated in Table 22, most mothers believed that their children were receiving the services they needed, were well cared for, and were safe. However, 19% of mothers believed that their children were *not* receiving needed services.

Table 22. Mothers' Perceptions of the Services Received by Their Children

	Strongly Disagree % (*n*)	Disagree % (*n*)	Agree % (*n*)	Strongly Agree % (*n*)	Don't Know % (*n*)
My child has received the services she/he needs. (N=130)	6% (8)	13% (17)	47% (61)	29% (38)	5% (6)
My child is well cared for in her/his current living situation. (N=121)	4% (5)	1% (1)	49% (59)	45% (54)	2% (2)
My child is safe in her/his current living situation. (N=121)	3% (3)	1% (1)	47% (57)	47% (57)	3% (3)

As illustrated in Table 23, most mothers (79%) felt that their children exhibited positive social behavior often, 20% felt their children exhibited positive behavior sometimes, and only one parent felt that their child did not exhibit positive social behavior. A majority of mothers felt that their children did not exhibit behavior problems, but 37% said that their children sometimes did have behavior problems.

Table 23. Mothers' Reports of Their Children's Behavior

	Not True % (*n*)	Sometimes / Somewhat True % (*n*)	Very / Often True % (*n*)
Positive Social Behavior (N=85)	1% (1)	20% (17)	79% (67)
Behavior Problems (N=85)	64% (54)	37% (31)	0

Summary

Taken together, these findings begin to paint a picture of the types of mothers who participate in FTDC, and the range of services that they are provided. On average, these mothers entered drug court with fairly serious drug and alcohol problems, having used drugs for many years and reporting serious life problems associated with their drug use. These mothers also report a relatively high level of co-occurring mental health disorders, including depression, anxiety, and suicidality. Interestingly, these mothers generally reported fairly high levels of social support and low levels of stress, perhaps because the baseline interviews were conducted once child welfare and/or FTDC supports were in place. Mothers reported needing a wide variety of ancillary services, and from their perspective there appears to be need for improvement in these areas. Fewer than one-third of the mothers that needed such important supports such as domestic violence services, housing assistance, health insurance, and child care actually reported being helped in these areas.

In terms of FTDC engagement and retention, most mothers entered the FTDC fairly quickly (within about 100 days of petition), and graduation rates, at least at the two more "traditional" FTDC models, were very high. Mothers also remained in FTDC for about one year in those sites—consistent with the basic program model. Graduation rates in San Diego were considerably lower, indicating difficulties successfully serving these families with the FTDC model. It may be that delaying these mothers' entry into the FTDC by enrolling them in the less intensive SARMS services first is problematic, in that they do not receive intensive support in the critical early months of their child welfare case. Instead, these mothers struggle and fail with treatment repeatedly before being provided a higher level of support, which may undermine, rather than enhance, their chances for success.

CHAPTER 5: WHAT MAKES FAMILY TREATMENT DRUG COURTS WORK? UNPACKING THE BLACK BOX OF FTDCS

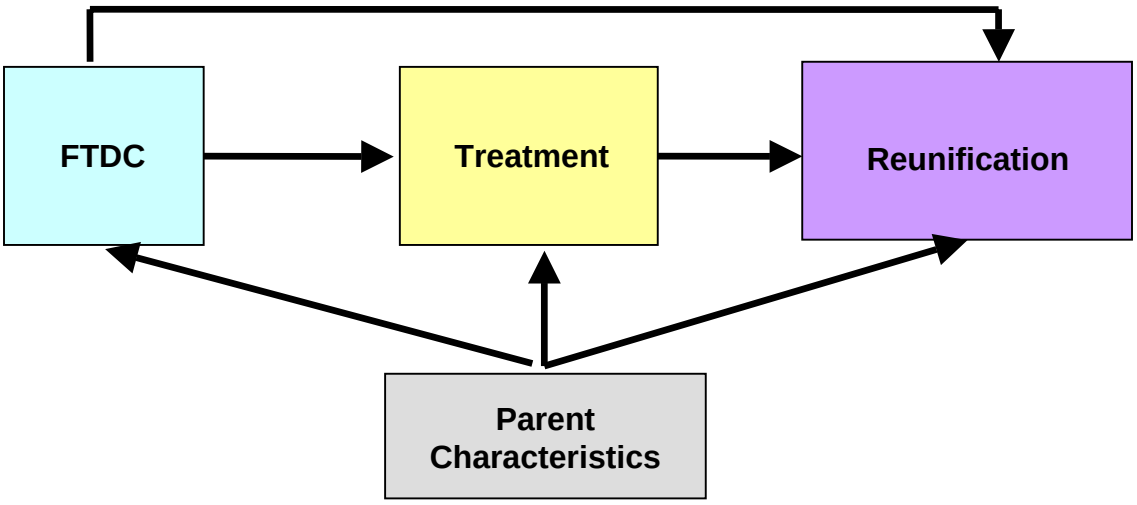
Results presented in the previous chapters suggest that there is consistent evidence that FTDC programs are successful in improving both treatment and child welfare outcomes, at least for programs employing a more "traditional" FTDC approach. This final chapter begins to explore the question of how FTDCs work, using the model shown in Figure 16 as a framework. Specifically, we present analyses linking: (1) FTDC experiences to treatment and child welfare outcomes; (2) treatment experiences to child welfare outcomes; and (3) parent characteristics to FTDC experiences and outcomes. These analyses draw on both administrative and interview samples. More detailed statistical results are presented in Appendix G. The first sets of analyses include only the within-FTDC sample, to examine variation in outcomes within the FTDC intervention. Towards the end of the chapter we then explore two questions that include the comparison group in order to address (1) Whether FTDCs are differentially effective for subgroups of mothers (that is, are outcomes particularly positive — or negative — for specific subgroups of mothers); and (2) Whether FTDC program effects are primarily accounted for by the impact of FTDCs on treatment completion, or whether there is a direct influence of the FTDC program that is separate from its positive influence on treatment.

Figure 16 shows the basic conceptual model that guided the analyses for this final chapter. We present analyses using both administrative and interview samples to examine the relationship between

the components of the figure — mothers' FTDC experiences, treatment experiences, demographic and other characteristics, and how these relate to both treatment outcomes and reunification.

For these analyses, parent-level treatment outcomes were analyzed using hierarchical regression for continuous outcomes (e.g., time spent in treatment), and hierarchical logistic regression for binary outcomes (e.g., completed at least one treatment, yes or no). The child-level outcome, reunification, was analyzed using Linear Mixed Modeling to adjust the error terms in an effort to reduce the bias introduced by nested data. Models of FTDC and treatment program variables also controlled for a number of parental background characteristics: 1) site, 2) demographic risk (unmarried, unemployed, no high school diploma), 3) age, 4) race/ethnicity, 5) history of mental health issues, 6) previous CPS involvement, 7) age of first drug use, 8) children's age, and 9) child risk factors.

Figure 16. Conceptual Model for Understanding How FTDC Works

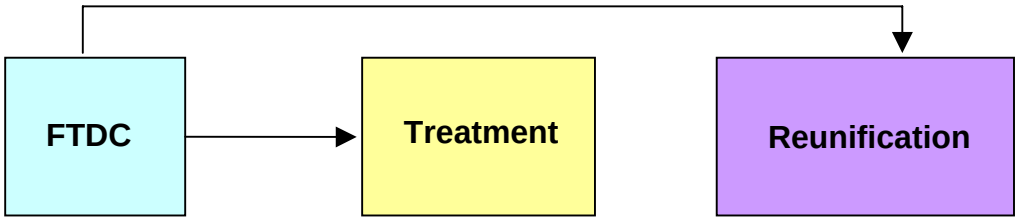


Relationship Between FTDC Experiences and Outcomes

The first set of analyses explores the paths shown in Figure 17. Regression models were conducted to examine whether any of the following variables predicted the four primary treatment outcomes (likelihood of entering treatment, time to treatment, days in treatment, and treatment completion) and the likelihood of reunification:

1. Time from child welfare petition to entry into the FTDC;
2. Total number of days in the FTDC program;
3. Total number of FTDC appearances;
4. FTDC graduation status (graduated vs. terminated or still pending).

Figure 17. How FTDC Experiences Influence Outcomes



As can be seen in Tables 24-27, FTDC experiences are associated with treatment and reunification outcomes. How quickly mothers enter the FTDC, not surprisingly, is also associated with how often and how quickly they enter treatment services. Mothers who entered the FTDC more quickly post-petition also tended to be more likely to enter treatment services, and to enter them more rapidly. How quickly mothers entered the FTDC, how-

ever, did not predict ultimate treatment completion or reunification.

The amount of time and intensity of FTDC services, however, were associated with treatment and reunification outcomes. Mothers who spent more days in FTDC and had more FTDC appearances stayed in treatment longer, were more likely to complete treatment, and were more likely to be reunified with their children. Moreover, not surprisingly, those who graduated from FTDC showed more positive outcomes as well — although the directionality of these relationships cannot be determined from these analyses. However, it is likely that treatment experiences, specifically, remaining in and completing treatment, usually precede (and therefore contribute) the likelihood of FTDC graduation.

Table 24. Relationship Between Time to FTDC Entry and Outcomes

Relationship Between Time to FTDC Entry and:	Statistically Significant?	Nature of Relationship
Likelihood of treatment entry	YES	Mothers entering FTDC more quickly were more likely to enter treatment.
Time to treatment entry	YES	Mothers entering FTDC more quickly also entered treatment more quickly.
Time spent in treatment	NO	No relationship
Treatment graduation	NO	No relationship
Likelihood of reunification	NO	No relationship

Table 25. Relationship Between Time Spent in FTDC and Outcomes[8]

Relationship Between Time Spent in FTDC and:	Statistically Significant?	Nature of Relationship
Time spent in treatment	YES	Mothers who spent more time in FTDC also spent more time in treatment
Treatment graduation	YES	Mothers who spent more time in FTDC were more likely to complete treatment.
Likelihood of reunification	YES	Mothers who spent more time in FTDC were more likely to be reunified with their children.

[8] Time spent in the FTDC was calculated in the Suffolk site using petition date as a proxy for drug court entry date, therefore the time in FTDC may be somewhat overestimated for this site.

Table 26. Relationship Between Number of FTDC Appearances and Outcomes

Relationship Between Number of FTDC Appearances and:	Statistically Significant?	Nature of Relationship
Time spent in treatment	YES	Mothers with more FTDC appearances also spent more time in treatment.
Treatment graduation	YES	Mothers with more FTDC appearances were more likely to complete treatment.
Likelihood of reunification	YES	Mothers with more FTDC appearances were more likely to be reunified with their children.

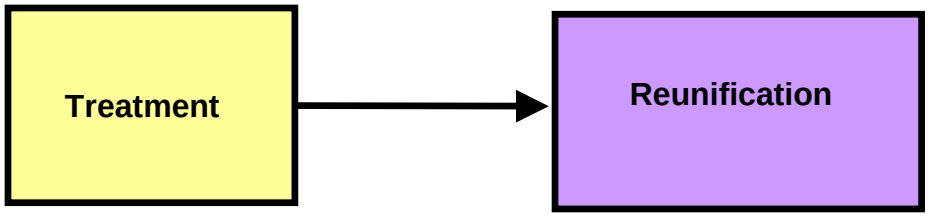
Table 27. Relationship Between FTDC Graduation Status and Outcomes

Relationship Between Graduate Status and:	Statistically Significant?	Nature of Relationship
Time spent in treatment	YES	Mothers who graduated from FTDC spent more time in treatment.
Treatment graduation	YES	Mothers who graduated from FTDC were more likely to have completed treatment
Likelihood of reunification	YES	Mothers who graduated from FTDC were more likely to be reunified with their children.

Relationship Between Treatment Experiences and Outcomes

Next, we examined the relationship between treatment experiences, specifically how quickly mothers were able to enter treatment and how long they remained in treatment, and two primary outcomes: treatment completion and reunification. These paths are shown in Figure 18.

Figure 18. Do Treatment Experiences Relate to Reunification?



As illustrated in Table 28, while time to treatment and time spent in treatment were related to a higher likelihood of treatment completion, these factors were not related to the likelihood of reunification. However, those mothers who completed treatment were more likely to be reunified with their children.

Table 28. Relationship Between Treatment Experiences and Outcomes

Relationship Between Time to Treatment and:	Statistically Significant?	Nature of Relationship
Treatment completion	YES	The more quickly mothers entered treatment, the more likely they were to complete treatment.
Likelihood of reunification	NO	No relationship
Relationship Between Time Spent in Treatment and:	**Statistically Significant?**	**Nature of Relationship**
Treatment completion	YES	The more time mothers spent in treatment, the more likely they were to complete treatment.
Likelihood of reunification	NO	No relationship
Relationship Between Treatment Completion and:	**Statistically Significant?**	**Nature of Relationship**
Likelihood of Reunification	YES	Mothers who completed treatment were more likely to be reunified with their children.

INTERVIEW FINDINGS: RELATIONSHIP BETWEEN PARENTAL REPORT OF TREATMENT EXPERIENCES AND OUTCOMES

Using the interview data subsample of FTDC mothers (n=136) we examined whether mothers' reports of aspects of their treatment services were related to either treatment outcomes or reunification.

Several interview variables were significant predictors of treatment completion. Results suggested that:

- Parents who reported more frequent urinalyses spent more time in treatment and were more likely to complete treatment.
- Mothers who reported meeting more frequently with their treatment counselor spent more time in treatment and were more likely to complete treatment.
- Mothers who reported having a more positive relationship with their treatment counselor were more likely to complete treatment.

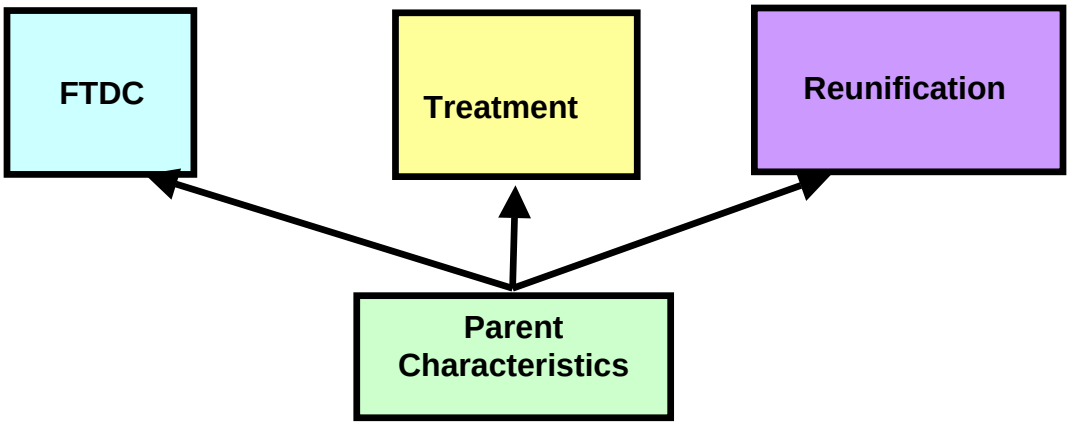
Only one of the interview variables related to treatment was a significant predictor of reunification. Specifically, mothers who reported meeting more frequently with treatment counselors were more likely to be reunified than those reporting less frequent meetings.

While examining the quality of treatment provided to FTDC participants was beyond the scope of this study, these results do suggest that quality treatment is important, and in particular, suggest that monitoring (in the form of UA's); regular visits with treatment counselors; and the relationship between parents and their treatment counselor are important components of parents' treatment experiences.

Relationship Between Parent Characteristics at Program Entry and FTDC Experiences

The next two sections examine the influence of mothers' demographic and other characteristics at FTDC program entry and their FTDC experiences, treatment outcomes, and reunification (see Figure 19).

Figure 19. Who Does Better in FTDC?



The first set of analyses examines the relationship between parent characteristics as they enter the FTDC and their retention and graduation from FTDC. We used a range of variables extracted from the administrative data sources to explore this question. Specifically, we ran a series of regressions controlling for site, and testing each of the following parent characteristic separately as predictors:

- Parent race/ethnicity
- Employed vs. unemployed
- High school diploma or better (yes or no)
- Child risk index (the total number, 0-8, of the following that described any one of the children: chronic medical problems, developmental/educational difficulties, behavioral/emotional issues, alcohol and/or drug abuse, prenatal substance exposure, sexual acting out or abuse toward others, prior sexual abuse, other)
- Mother's age at first drug use
- Whether the mother's primary drug of choice was methamphetamine (yes/no)
- Parent's age at FTDC entry
- Whether there were indications of a mental health issue for the mother (yes/no)
- Previous CPS involvement (yes/no)
- Whether the mother had at least one infant (yes/no)
- Whether the mother had at least one toddler (yes/no)
- Whether the mother had at least one older child (yes/no)

Very few of these parent characteristics were significantly related to FTDC experiences. Specifically:

- Mothers with children with more risk factors spent more days in FTDC.
- Mothers with infants were somewhat more likely to graduate from FTDC, while mothers with toddlers were somewhat less likely to graduate.

Overall, however, the primary differences in FTDC experiences were related to site variability, as reported in Chapter 3.

Relationship Between Parent Characteristics at Program Entry and Outcomes

The next set of analyses examined the relationship between the same set of parent characteristics described above and treatment and child welfare outcomes.

Again, few of these parent characteristics were significant predictors of any of the treatment variables (likelihood of entry, time to treatment entry, days in treatment, or treatment completion). Specifically:

- The parent characteristic most frequently associated with treatment outcomes was mothers' educational status: those mothers with less than a high school education were less likely to enter treatment, spent fewer days in treatment, and were less likely to complete treatment.
- Older mothers were less likely to enter treatment and to complete treatment.
- Mothers with toddlers spent more days in treatment, while mothers with infants were more likely to complete treatment.
- Having a toddler (vs. not having a toddler) was also the only characteristic associated with reunification – mothers with a toddler were somewhat more likely to be reunified.

Overall, these results suggest that there are few differences in outcomes for mothers participating in FTDC who enter the program with different kinds of characteristics, at least as measured in this study. It could be that the FTDC model is appropriate for a wide variety of parents and therefore is equally effective with families with diverse backgrounds. However, measurement is an important consideration; specifically, this study relied on administrative data sources for information about such issues as mental health status. Mental health assessments were not consistently conducted, nor were mental health issues consistently recorded by child welfare staff. Thus, this measure of mental health status is likely to significantly under-report the prevalence of mental health issues. Further, many of these parent characteristics were not equally distributed across the site (e.g., race, use of methamphetamine), and thus, it is difficult to know whether a given result might be due to the underlying parent characteristic or to the confounding variable of site. For example, the majority of African American participants were from the San Diego site, where outcomes were less positive. Thus, these results should be interpreted with caution and be considered preliminary; further research on the extent to which parent characteristics influence FTDC outcomes is clearly needed.

Does the FTDC Program Have Different Impacts for Mothers with Different Characteristics?

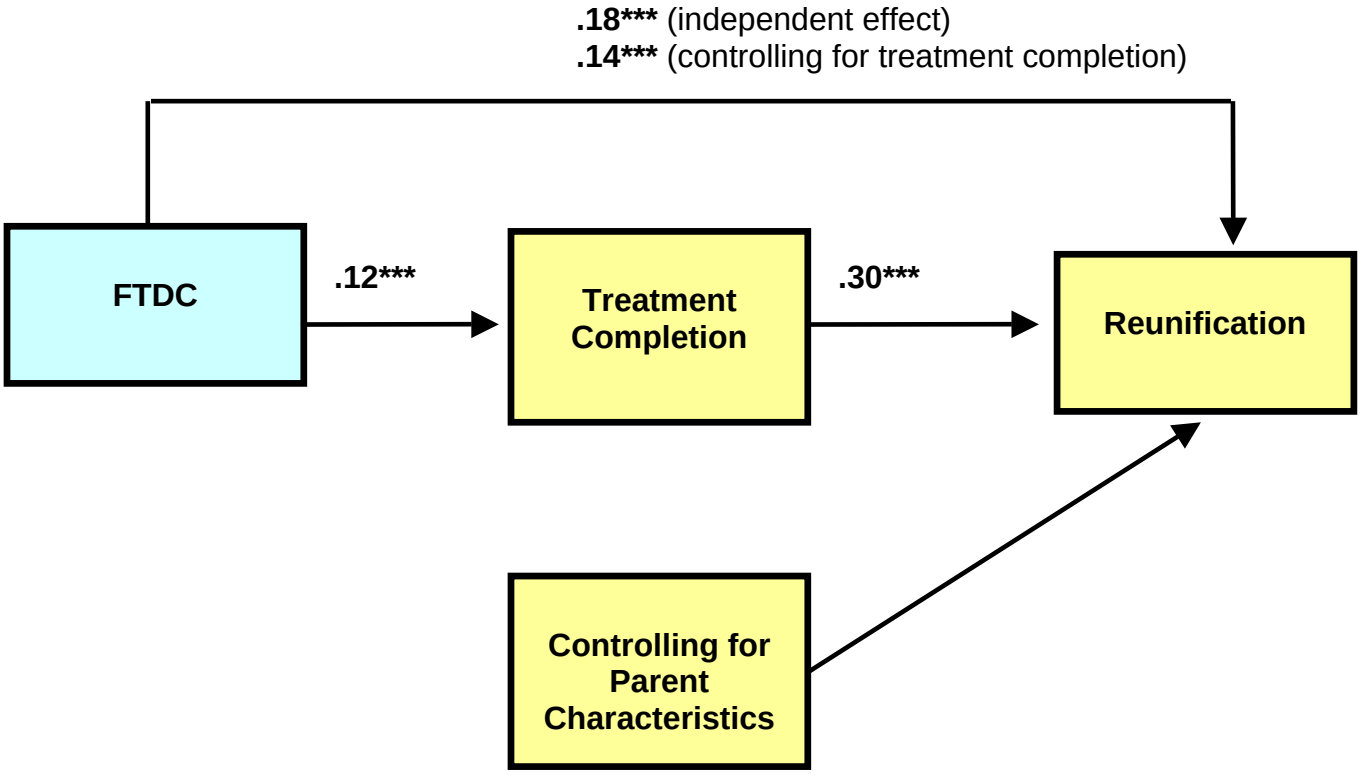
The next set of analyses test whether FTDC effectiveness is *moderated* by any parent characteristics. To determine this, a series of regression analyses were conducted that included both the FTDC and comparison group samples, and which tested for interactions between FTDC status (treatment/comparison group) and each parent characteristic tested separately. Thus, these analyses address the question of whether FTDC may work better (or worse) for certain subgroups of mothers. Subgroups that were tested included each of the parent characteristics described above for the within-FTDC analyses. Each analysis controlled for the

set of parent characteristics, site, and then included the targeted interaction term. Overall, however, there were no significant interactions for any subgroups; three were marginally significant ($p<.08$), and suggested that FTDCs may be especially helpful in supporting treatment entry for mothers with mental health issues and with higher demographic risk. The only other significant interaction, not surprisingly, was the Site X FTDC interaction, which mirrored the outcomes presented in Chapter 3 showing site differences in many of the major outcomes.

Unique Effects of FTDC Programs: Testing a Mediational Model

The final analyses we conducted examined the question of whether the positive effects of the FTDC program on rates of family reunification were due exclusively to the ability of the FTDC to support positive treatment outcomes, or whether there was "value added" above and beyond the impact of treatment experiences. Results from the retrospective study suggested that participating in the FTDC program did contribute significantly to the chances of reunification above and beyond the influence of treatment experiences (Green et al., 2007). To address this question, we ran a series of regression models testing whether the impact of FTDC participation on reunification outcomes was mediated by its effect on treatment completion. If a mediational model was supported, (e.g., if the significant relationship between FTDC status and reunification was eliminated when treatment completion was included in the model) this would suggest that the primary pathway through which FTDCs influence reunification is through treatment completion. If results showed that the relationship between FTDC and reunification remained significant, after controlling for treatment completion, this would support a "value added" model of program effects (Baron and Kenny, 1986). In fact, as shown in Figure 20, results supported the latter: Mothers who participated in the FTDC program did experience higher rates of treatment completion, which in turn were associated with higher rates of reunification; however, participating in the FTDC also contributed to the likelihood of reunification above and beyond its effect on treatment. In other words, mothers who participated in FTDCs who completed treatment were more likely to be reunified than comparison group mothers who had similar treatment experiences.

Figure 20. Are Program Effects Due Only to Impact on Treatment Completion?



***statistically significant, p<.001

Results from the Qualitative Study: Parent and Key Stakeholder Explanations of What Makes FTDC Work

Through the course of the 4-year evaluation effort, mothers and key stakeholders from the study sites shared their impressions of the key ingredients of FTDC and those things that either help, or hinder, parental progress.

Features that Contribute to Parent Success

Mothers spoke eloquently about the features of FTDC that influenced their progress, and several key features of FTDC emerged, including emotional support, accountability and collaboration, practical support, and a sense of accomplishment from graduation. In addition to mothers' perspectives, key stakeholders discussed how certain characteristics of the judge led to program success. Below we describe each of these themes.

Emotional Support

Mothers talked about how FTDC participation provided a support system. Mothers described what it was like to have "a team of people around you to support your recovery." The team members most often mentioned were the judges, dedicated FTDC caseworkers, and in the case of one site, foster grandmothers (foster

grandmothers are volunteers from the elder community who work with mothers throughout the FTDC program, filling a parenting void for many of the participants). Mothers talked about the judge as more than an authority figure, but a person that is invested in mothers' success and who is supportive of, and rooting for, them:

> "*She (the judge) is respectful to the fact that we've had a drug problem and she doesn't judge us for it . . . She makes sure that if you need anything, and I ask for it, I get put in the right direction in getting what I need . . . She's rooting for us to be successful."*

Although at all study sites several mothers discussed frustration and distrust of child welfare workers, mothers actively involved with FTDC expressed a much more positive attitude towards their drug-court dedicated child welfare caseworkers. Whereas non-FTDC mothers generally told us that they felt caseworkers were not working in their interest, FTDC mothers, overall, felt supported by FTDC dedicated child welfare caseworkers.

> *"The FTDC team and the FTDC case worker have helped me a lot. My first case worker, that wasn't the FTDC one, didn't spend much time with me, but my FTDC case worker always knew what was going on with me, and helped me get what I needed to get my kids back."*

Accountability and Collaboration

Mothers also explained how frequent hearings and attendance in FTDC provided accountability for their behavior because "the team knows what's going on with you and you get immediate support for whatever is going on as soon as you need it." Participating in FTDC also helped participants "keep going" or stay engaged by attending court frequently, which they reported helped them to resolve issues quickly. One parent said, "it's helpful going every two weeks because things can come up during that time, and in FTDC these problems are addressed quickly." Another parent stated, "criminal court is about punishment while FTDC is more about resolution of problems."

Frequent court attendance means that the judge and others are well informed about the mothers' cases and able to provide appropriate support for recovery and other issues facing the parent. One parent stated that having the judge and other team members know what's going on in your life: "helps you feel less alone, that someone knows what's going on in your life and the all the issues that you face, they know how to support you and what you need." For only a few mothers being "under the microscope" was seen as a negative. These mothers felt as if being in FTDC meant people knew too much about "their business." However, most mothers felt that frequent attendance also facilitated agreement on the case; one parent commented that she could not believe how easily people seem to agree in FTDC: "even the district attorney is in agreement about my case."

Practical Support

Participants in FTDC also receive practical assistance. Not only did mothers discuss how the FTDC helped get them housing and employment, but also helped with life improvement needs such as tattoo removal, dentures and obtaining birth control. These practical and external supports increase mothers' sense of confidence and ability to make improvements in their lives.

Sense of Accomplishment

Mothers who graduated from FTDC spoke eloquently about the significance of graduation. Mothers discussed how graduation from FTDC gave them a sense of accomplishment, some for the first time in their life. Others discussed that through participating in and graduating from FTDC they learned "how to have the kind of life I've always wanted, but didn't know how to get." Graduation from FTDC also made mothers feel that they were important, special, and that they mattered.

> "*It (graduation) was great. Everyone applauded for me, I got a hug from the Judge, and they gave me flowers. I felt like a beauty queen. I also felt that my graduated meat that I finished something I started, and this is the first time I ever accomplished something like this in my life. Now I feel like I can succeed in life.*"

Judicial Characteristics

FTDC team members described the judicial characteristics they believed to be related to successful FTDC experiences. FTDC team members stated that judges who are consistent, straightforward, and clear decision-makers are most effective. Judges who have these characteristics help clients know what to expect and help keep clients accountable. It is also important to FTDC team members that the judge be an active member of the FTDC team, which in turn encourages the collaborative nature that is so important to FTDCs. FTDC team members reported that they need a judge who is an active partner, encourages open communication among the team, is knowledgeable about client's cases, will follow the team recommendations, and will make appropriate sanctions or therapeutic recommendations based on the team recommendations.

JUDICIAL TRANSITIONS

All four study sites experienced turnover in FTDC judges over the course of the 4-year evaluation. Given the importance of the parent-judge relationship that has been hypothesized as a key component of drug court effectiveness (Carey, Finigan, and Cox, 2007), and the overall role of the judge in setting the tone for the FTDC program, we felt it important to attempt to understand the conditions that supported smoother judicial transitions. Key informants, primarily members of the FTDC policy teams at two sites, shared their experiences with the judicial transitions at their sites. Below we offer suggestions for ensuring successful judicial transitions.

Features That Encourage Smooth Transitions

The primary feature described by key stakeholders that encourages smooth transitions is continuity. Informants discussed the importance of the new judge operating the FTDC in the same way and making no immediate changes in day-to-day operation. Stakeholders also recommended the early involvement of the new judge prior to the transition, and the importance of a mentoring relationship between the new judge and the departing judge, which encourages the new judge to commit to learning the program and building relationships with the team and clients. Finally, informants discussed the importance of a strong FTDC team that is not dependent on one person, which results in the program's perseverance and growth despite judicial turnover.

> *"I think it helped that the (previous judge) had me involved even before*

the transition; he was essentially getting me ready to take the court over when he retired. Putting that trust in me showed people that he was backing me and had faith in what I would do and that I would follow in his footsteps. He was my mentor."

Informants discussed that smooth transitions: (1) minimize the impact on mothers, (2) result in no immediate changes in day-to-day operation, and (3) lead to positive changes in the team and for mothers when everyone is working with continuity toward a common goal.

CHAPTER 6: CONCLUSIONS

Results from this study show strong evidence for the effectiveness of the FTDC program on treatment and child welfare outcomes, especially for programs adopting a more "traditional" FTDC model. This traditional model includes a focus on mothers whose children have been removed from their care, and involves frequent court appearances, timely access to quality treatment services, and a focus on longer-term support for mothers as they work towards recovery. In both the Santa Clara and Washoe FTDC sites, which reflect this basic model (albeit with variations in the detailed program structure and the types of ancillary services provided), results found that participation in FTDC was associated with statistically and practically significant results:

- 55%-60% increases in the length of stay in treatment services for participants;
- 40%-54% increases in the rates of treatment completion for participants;
- 14%-36% reductions in the number of days spent in out-of-home placements;
- 42%-50% increases in the percentage of children reunified with their mothers.

Results in the other two sites were more mixed. In Suffolk County, treatment outcomes were quite positive, paralleling those found for Santa Clara and Washoe, and reflecting the success of the FTDC program in securing treatment services and supporting mothers to remain in and complete treatment. However, placement outcomes did not show the same pattern of positive outcomes. This may be due to

several conditions unique to that site. First, the majority of children were never placed out of home, and thus, although these families were included in the calculation of "reunified" (e.g., these families were counted as "reunified" because they successfully remained with their mothers for the duration of their case), the comparison families were likely to be at similar (lower) risk for placements other than reunification. Second, Suffolk County had unusually long child welfare cases, and in fact 57% of the cases in the study were not yet closed at the end of the two-year study window. Permanency results for these families, therefore, were not included in these analyses.

Results were least favorable for the San Diego Dependency Court Recovery Project model. There were no significant differences between families served by the DCRP, either in the Family Drug Court or in the SARMS system, and a well-matched comparison group from two other California counties. While there are drawbacks to using a comparison county approach, it should be noted that the results for the DCRP system group are consistently less positive when compared to the FTDC participant groups in the other three sites (with the exception of statistically significant but small positive effects

for services delivered and reunification rates). In fact, the overall level of outcomes for the DCRP group look more similar to the comparison groups across the four sites than to the FTDC treatment group outcomes. Reasons for these less positive outcomes are not clear, although several can be speculated. First, there were significant implementation issues during the study period, which may have influenced the success of the program. The founding judge and program developer retired early in the study, leading to some difficult transition issues. Further, funds to the program were cut significantly, leading to waiting lists for program participants (a situation that had not happened previously), and other reductions in support services. Qualitative interviews with mothers in the SARMS program suggested that they were not satisfied with the level of services and support that were being provided by the SARMS specialists. It is likely that these problems contributed to the lack of positive outcomes.

It may also be that the model, as it currently operates, does not represent the best approach, especially for higher risk mothers. The DCRP model calls for all mothers with substance abuse issues to participate in SARMS services for a period of time; mothers who are noncompliant or unsuccessful with treatment are then referred to the FTDC, usually after 2 or more indications of noncompliance with treatment orders. Given research that suggests that mothers' entry into the child welfare system may represent an immediate "window of opportunity" for intervention in which motivation to succeed in treatment is highest, these delays and indeed, the repeated failures, may eventually undermine mothers' motivation and lead to less successful outcomes. A better approach, still using the system-wide framework, might be to triage mothers after the substance abuse assessment and assign higher-risk mothers immediately to the FTDC, while lower-risk mothers go through the SARMS system. This approach would provide the more intensive FTDC services to those who may benefit the most, but without delays and treatment failures prior to FTDC entry.

Results of this study also begin to provide some information about what is important to successful FTDC programs. There were few differences in outcomes for mothers with a wide range of demographic, case, and substance abuse characteristics. This suggests the model is successful with a wide range of participants. However, successful mothers were those who had timely access to treatment services and who were able to remain in and complete treatment. More successful mothers also reported more frequent contact with their treatment providers, and more frequent urinalysis. Mothers who remained in FTDC longer, and had more FTDC appearances, also tended to be more successful. However, there were differences in the average number of FTDC appearances between Santa Clara and Washoe, which both had quite positive outcomes. Research to determine the level of FTDC services that are most appropriate is clearly needed. Findings from this study also indicate that while FTDCs' influence on treatment experiences is significant and an important factor in mothers' success, FTDC participation itself, apart from its influence on treatment experiences, also contributed to mothers' success. Qualitative data from this study suggest that importance of such factors as support from the drug court team and parental relationships with the judge; further research is necessary to understand the "value added" of FTDCs.

It is also clear that success for FTDC mothers takes time — most mothers remained in the drug court for about a year, and thus tended to have longer court cases and took longer to reach a permanent placement. More research on the timing, intensity, and duration of the FTDC services is clearly needed. This finding also has clear implications for child welfare policy. Given the timelines mandated by AFSA, and the fact that the proliferation of FTDCs has occurred in large part in reaction to ASFA, the fact that this study found no indication that FTDC cases reach permanency faster, raises questions about whether reduced time to permanency is a realistic goal for mothers in the FTDC program. However, it should also be noted that permanent placements were made, on average, in less than one year in all sites, well within ASFA timelines.

STUDY LIMITATIONS

Finally, it is worth noting that this study did not find significant differences between mothers served in the FTDC and mothers processed through traditional child welfare services in terms of re-entry to the child welfare system. However, the overall rates of recidivism into the child welfare system were quite low, and it is likely that the study was simply too short in duration to effectively capture recidivism. One potentially significant finding was the lower rate of mothers who gave birth to an infant with a positive toxicology screen, a result that was statistically significant for both Santa Clara and Washoe. However, the number of mothers with subsequent pregnancies during our time frame was quite small (only 14 and 16 in the two FTDC groups) so these results should be interpreted cautiously. Moreover, results from this study suggest that recidivism for both mothers ***and*** children is more likely for cases that originally ended in a termination of parental rights. This suggests that, at least for this sample, recidivism is due less to reunifications failing than to cases in which underlying substance abuse and other issues were not successful resolved. Further research that can track recidivism at both the child and parent level for a longer period of time is needed to provide more confidence in this and other recidivism findings.

While data from the current study presents a compelling case for the efficacy of the FTDC model, there were several limitations to the study that are worth noting. First, there are always risks with a quasi-experimental design, particularly one that utilizes a comparison county approach, that the comparison group is not equivalent to the treatment group, and therefore that differences in treatment effects are in fact due to differences between the groups in other, unmeasured characteristics. Mitigating this argument, however, is the fact that there were few differences in outcomes based on a wide range of family, psychosocial, child welfare case, or treatment characteristics, at least those measured in this study. Second, we found few significant differences between treatment and comparison groups on a large number of demographic and background characteristics. Third, we used propensity score weighting in an effort to further reduce any potential bias in effect size estimates. Finally, outcomes for the comparison group that was drawn from comparison counties were similar to the outcomes for the other (within-county) comparison groups, suggesting that families in the comparison county group had experiences similar to those of the other comparison groups. Thus, while quasi-experimental designs do not provide the same level of confi-

dence in outcomes as randomized trials, it is clear this study used a strong quasi-experimental design that introduced few plausible alternative explanations for the positive treatment effects.

Second, due to the low caseflow at the study sites, the interview samples were quite small, which posed a challenge for statistical analyses. Further, we did not have comparison groups for the interview data, so comparative analyses on the interview variables was not possible. As a result, the set of questions that could be answered by the interview component of the study was limited. The interview component allowed us to gather information from parents about their psychosocial characteristics and their FTDC experiences and to look for links between these variables and case outcomes. However, without similar data from a comparison group it is not possible to answer questions about how parent characteristics and perceptions of their cases differentially affect outcomes for FTDC parents as compared to parents undergoing traditional child welfare case processing.

Third, any study of this sort is limited by the availability of data. In this case, administrative records of parent and child risk variables (e.g. mental illness, domestic violence) were quite incomplete at each of the four study sites. Therefore, this study likely under-represents the prevalence of these issues. Our analyses indicate that few parent characteristics influenced case outcomes, but this finding could be due to the fact that we simply did not have adequate data for this set of analyses.

Finally, this study had a two-year data collection window; that is, we collected data for two years post-petition. Given the average length of the cases studied and the fact that a sizeable proportion of cases remained open at the close of the two-year window, it was not possible to adequately track these families after case closure.

In sum, the current study provides strong initial evidence that Family Treatment Drug Courts can have a positive influence on outcomes for children and families. Future studies, using randomized or other strong quasi-experimental designs, which can gather more accurate data about mental health and other potentially important moderating variables, which can more systematically test model differences in FTDC approaches, and which can follow families for longer periods of time are needed in order to continue to build a strong evidence base for the FTDC model.

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APPENDIX A: SAMPLE DESCRIPTIONS

Table A1. San Diego Sample Demographics

Characteristic	Tier 1 Sample	Tier 2 Sample	Comparison Sample
	% (n)	% (n)	% (n)
Race	N=317	N=99	N=202
Caucasian	47% 148	51% (50)	53% (107)
African American*	13% (41)	20% (20)	21% (43)
Hispanic	31% (98)	22% (22)	24% (48)
Other*	10% (30)	7% (7)	2% (4)
Education Level	N=303	N=97	N=63
Less than high school	40% (120)	55% (53)	48% (30)
Employment status	N=276	N=90	N=92
Employed	24% (66)	12% (14)	13% (12)
Marital Status	N=330	N=102	N=197
Legally married	25% (247)	22% (80)	22% (44)
Age	N=334	N=104	N=205
Mean	30	28	30

*The comparison sample had significantly more African Americans and fewer "other" parents than the combined SARMS/Drug Court group.

Table A2. Santa Clara Sample Demographics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Race	N=100	N=552
Caucasian	33% (33)	38% (208)
African American	8% (8)	10% (53)
Hispanic	53% (53)	42% (234)
Other	6% (6)	10% (57)
Education Level	N=70	N=265
Less than high school	56% (39)	49% (129)
Employment status	N=46	N=238
Employed	15% (7)	23% (54)
Marital Status	N=95	N=526
Legally married	10% (9)	16% (85)
Age	N=100	N=552
Mean	29	30

Table A3. Suffolk Sample Demographics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Race	N=117	N=238
Caucasian	77% (90)	71% (169)
African American	13% (15)	20% (47)
Hispanic	9% (10)	17% (7)
Other	2% (2)	2% (5)
Education Level	N=59	N=100
Less than high school	29% (17)	23% (23)
Employment status	N=85	N=193
Employed	21% (18)	31% (60)
Marital Status	N=117	N=237
Legally married	28% (33)	28% (67)
Age	N=117	N=238
Mean	34	34

Table A4. Washoe Demographics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Race	N=83	N=125
Caucasian	81% (67)	72% (90)
African American	6% (5)	6% (8)
Hispanic	4% (3)	10% (12)
Other	10% (8)	12% (15)
Education Level	N=76	N=97
Less than high school	61% (46)	54% (52)
Employment status	N=82	N=126
Employed	17% (14)	12% (15)
Marital Status	N=83	N=126
Legally married	37% (31)	38% (48)
Age	N=84	N=127
Mean*	28	31

*Drug court sample was significantly younger than the comparison sample.

Table A5. San Diego Substance Use Characteristics

Characteristic	Tier 1 Sample	Tier 2 Sample	Comparison Sample
	% (n)	% (n)	% (n)
Primary drug of choice	N=206	N=74	N=136
Methamphetamine	53% (109)	64% (47)	52% (70)
Cocaine*	5% (11)	5% (4)	13% (17)
Marijuana*	18% (38)	14% (10)	10% (13)
Alcohol	18% (37)	12% (9)	21% (28)
Other	5% (11)	5% (4)	6% (8)
Mothers with at least one prior treatment episode	N=334 11% (37)	N=104 19% (20)	N=205 14% (29)
Age at first use	N=206	N=74	N=136
Mean	19	18	19

*Comparison parents were more likely than parents in the combined SARMS/Drug Court group to list cocaine and less likely to list cannabis as their drug of choice.

Table A6. Santa Clara Substance Use Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Primary drug of choice	N=85	N=335
Methamphetamine	54% (54)	57% (190)
Cocaine	8% (7)	7% (23)
Marijuana	9% (8)	8% (28)
Alcohol	14% (12)	20% (66)
Other	5% (4)	8% (28)
Mothers with at least one prior treatment episode	N=100 19% (19)	N=553 14% (96)
Age at first use	N=71	N=316
Mean	18	19

Table A7. Suffolk Substance Use Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Primary drug of choice	N=97	N=147
Methamphetamine	0	0
Cocaine	34% (33)	31% (46)
Marijuana	9% (9)	14% (20)
Alcohol	43% (42)	34% (50)
Other	13% (13)	21% (31)
Mothers with at least one prior treatment episode	N=117 32% (37)	N=239 25% (60)
Age at first use	N=97	N=147
Mean	22	21

Table A8. Washoe Substance Use Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Primary drug of choice	N=63	N=77
Methamphetamine	60% (38)	62% (48)
Cocaine	8% (5)	4 (3)
Marijuana	14% (9)	9% (7)
Alcohol	14% (9)	22% (17)
Other	3% (2)	3% (2)
Mothers with at least one prior treatment episode	N=84 11% (9)	N=127 11% (14)
Age at first use	N=63	N=77
Mean	18	18

Table A9. San Diego Child Welfare Case Characteristics

Characteristic	Tier 1 Sample	Tier 2 Sample	Comparison Sample
	% (n)	% (n)	% (n)
Allegations	N=331	N=104	N=204
Physical abuse*	9% (30)	9% (9)	17% (34)
Neglect*	77% (255)	88% (91)	93% (190)
Emotional abuse*	19% (62)	18% (19)	9% (18)
Mother with previous CPS referrals	N=331 51% (169)	N=104 60% (61)	N=195 45% (87)
Mother with previous terminations of parental rights*	N=332 11% (37)	N=103 19% (20)	N=201 8% (15)
Children's ages	N=333	N=104	N=205
At least one infant	57% (190)	67% (70)	59% (121)
At least one toddler*	44% (146)	51% (53)	56% (115)
At least one older child	43% (145)	28% (29)	46% (94)
Number of children	N=334	N=104	N=205
Mean*	1.9	2.0	2.4

*Comparison parents were significantly more likely than the combined SARMS/Drug Court group to have a toddler, were more likely to have allegations of physical abuse or neglect, were less likely to have allegations of emotional abuse or previous TPRs, and had more children.

Table A10. Santa Clara Child Welfare Case Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Allegations	N=100	N=553
Physical abuse*	5% (5)	16% (87)
Neglect	96% (96)	91% (502)
Emotional abuse*	7% (7)	15% (80)
Mother with previous CPS referrals	N=91 34% (160)	N=466 31% (28)
Mother with previous terminations of parental rights	N=100 6% (60	N=546 7% (37)
Children's ages	N=100	N=553
At least one infant*	69% (69)	57% (313)
At least one toddler	42% (42)	43% (235)
At least one older child	35% (35)	46% (251)
Number of children	N=100	N=553
Mean	2.0	2.1

*Drug court sample parents were significantly more likely than comparison group parents to have an infant, were less likely to have allegations of physical or emotional abuse.

Table A11. Suffolk Child Welfare Case Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Allegations	N=117	N=239
Physical abuse	1% (1)	3% (7)
Neglect	98% (115)	100% (239)
Emotional abuse	0	0
Mother with previous CPS referrals	N=116 38% (44)	N=236 33% (78)
Mother with previous terminations of parental rights	N=116 10% (11)	N=238 11% (27)
Children's ages	N=117	N=239
At least one infant	52% (61)	43% (102)
At least one toddler	37% (43)	38% (90)
At least one older child	62% (73)	62% (148)
Number of children	N=117	N=239
Mean	2.2	2.1

Table A12. Washoe Child Welfare Case Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Allegations	N=84	N=126
Physical abuse	2% (2)	7% (9)
Neglect	99% (83)	65% (120)
Emotional abuse	0	1% (1)
Mother with previous CPS referrals	N=84 % (37)	N=126 47% (59)
Mother with previous terminations of parental rights	N=75 5% (4)	N=90 6% (5)
Children's ages	N=84	N=126
At least one infant	64% (54)	54% (68)
At least one toddler	54% (45)	53% (54)
At least one older child*	29% (24)	42% (53)
Number of children	N=84	N=127
Mean	2.0	1.9

Table A13. San Diego Mother and Child Risk Factor Characteristics

Characteristic	Tier 1 Sample	Tier 2 Sample	Comparison Sample
	% (n)	% (n)	% (n)
Children's risk factors	N=333	N=104	N=205
At least one child with chronic health problem*	29% (98)	24% (25)	40% (81)
At least one child with developmental/educational issue*	12% (41)	16% (17)	20% (40)
At least one child with behavioral/emotional issue*	12% (39)	12% (12)	21% (42)
At least one child with prenatal substance exposure	28% (93)	41% (42)	28% (57)
Mother's risk factors	N=334	N=104	N=205
Indication of mental illness**	31% (104)	28% (29)	22% (46)
Learning or developmental disorder	2% (8)	4% (4)	2% (5)
Medical disability or condition**	12% (41)	15% (16)	5% (10)
History of domestic violence	58% (192)	62% (64)	46% (94)
Average child risk score Mean	N=334 1.0	N=104 1.1	N=205 1.2
Average mother risk score** Mean	N=330 2.3	N=102 2.3	N=204 1.8

*Comparison children were significantly more likely to have a chronic health problem, a developmental/educational issue, or a behavioral/emotional issue than children in the combined SARMS/Drug Court group

**Comparison mothers were more likely to have indications of mental illness and less likely to have a chronic medical condition or a history of domestic violence and had a lower number of total risks.

Table A14. Santa Clara Mother and Child Risk Factor Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Children's risk factors	N=100	N=553
At least one child with chronic health problem	40% (40)	37% (206)
At least one child with developmental/educational issue	28% (28)	25% (136)
At least one child with behavioral/emotional issue	24% (24)	27% (148)
At least one child with prenatal substance exposure*	49% (49)	31% (173)
Mother's risk factors	N=100	N=553
Indication of mental illness	30% (30)	32% (176)
Learning or developmental disorder	4% (4)	4% (22)
Medical disability or condition	7% (7)	5% (25)
History of domestic violence	67% (66)	59% (323)
Average child risk score Mean	N=100 1.5	N=553 1.3
Average mother risk score Mean	N=99 2.3	N=645 2.2

* Drug court children were significantly more likely to have prenatal substance exposure than comparison children.

Table A15. Suffolk Mother and Child Risk Factor Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Children's risk factors	N=117	N=239
At least one child with chronic health problem*	27% (31)	16% (38)
At least one child with developmental/educational issue	21% (25)	20% (47)
At least one child with behavioral/emotional issue	29% (34)	31% (73)
At least one child with prenatal substance exposure*	28% (33)	16% (37)
Mother's risk factors	N=114	N=237
Indication of mental illness	47% (53)	43% (101)
Learning or developmental disorder	2% (1)	0
Medical disability or condition	11% (7)	14% (20)
History of domestic violence	44% (52)	44% (105)
Average child risk score Mean	N=117 1.1	N=239 0.9
Average mother risk score Mean	N=65 2.4	N=140 2.2

*Drug court children were significantly more likely than comparison children to have a chronic illness or prenatal substance exposure.

Table A16. Washoe Mother and Child Risk Factor Characteristics

Characteristic	Drug Court Sample	Comparison Sample
	% (n)	% (n)
Children's risk factors	N=83	N=127
At least one child with chronic health problem	29% (24)	35% (45)
At least one child with developmental/educational issue	19% (16)	23% (29)
At least one child with behavioral/emotional issue	16% (13)	17% (21)
At least one child with prenatal substance exposure	36% (30)	65% (44)
Mother's risk factors	N=84	N=127
Indication of mental illness	39% (33)	48% (61)
Learning or developmental disorder	8% (7)	6% (7)
Medical disability or condition	13% (11)	15% (19)
History of domestic violence	67% (56)	62% (78)
Average child risk score Mean	N=83 1.1	N=127 1.3
Average mother risk score Mean	N=84 2.6	N=126 2.7

APPENDIX B: INTERVIEW INSTRUMENT

FAMILY IMPACT STUDY
BASELINE PARENT INTERVIEW

2104593958

Version2

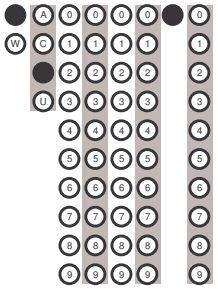
OMB NO: 0930-0249
Exp. Date: 10/31/06

A1. Site:

- ● San Diego
- ○ Santa Clara
- ○ Suffolk
- ○ Washoe

A2. Participant ID Number:

S D _ _ _ _ P _



A3. Interviewer:

_ _

A4. Indicate location of interview:

- ○ Respondent's Home
- ○ Other Home
- ○ Residential Treatment
- ○ Other: _____

A5. Date of interview:

_ _ / _ _ / _ _

A6. Time interview started: ____:____ AM/PM

A7. Time interview completed: ____:___ AM/PM

A8. Participant is in:

- ○ Drug Court
- ○ Comparison Group
- ○ SARMS/Santa Clara general system

A9. Circle status of the interview:

- ○ Complete
- ○ Partially complete, second session scheduled
  Date rescheduled: ___ / ___ / ___
  ☐ Check here when complete
- ○ Partially completed, refused to continue

A10. Respondent Gender *[Coded by interviewer, not asked]:*

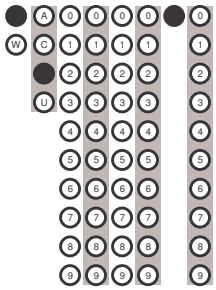
○ Male ○ Female

A11a. Target Child Name:

_____

[See interview QxQ for details on how to select target child.]

A11b. Target Child ID number: S D _ _ _ _ C _



A12. Target Child Age:

_____

A13. Which type of baseline is this?

- ○ Regular baseline interview
- ○ Modified baseline for the 1-3 months retrospective group (Suffolk or Washoe only)

A14. Petition Date: ___ / ___ / ___

A15. This interview was conducted in:

○ **English** ○ **Spanish**

Processing Information:	Initials	mo/day/yr
Checked by interviewer:	_____	___/___/____
Received by coordinator:	_____	___/___/____
Checked by coordinator:	_____	___/___/____
Data entered:	_____	___/___/____

NOTE TO INTERVIEWER: ITEMS IN ITALICS ARE MEANT FOR INTERVIEWER INSTRUCTIONS, AND SHOULD NOT BE REPEATED TO THE RESPONDENT.

Introduction and Consent:
Start Time:_____AM/PM

TAPED INTERVIEWS
[Read and complete Consent for Release of Taped Interview form]

Before we start, I want to thank you for your interest in this project and for agreeing to meet with me today. By completing this interview, you are helping to improve services for families like yours.
I have two forms here for your review. The first describes the project, what it means to be a participant, and your rights. I need to read this Informed Consent Form aloud, and to give you a copy that you can read and keep for yourself. If you agree to participate after I have read the entire Informed Consent, I will record a project ID number and your name, and we will both sign the form.
[Read and complete Informed Consent]
OK, this next form asks you for information about how to get in touch with you.
[Complete locator form]

Can we begin now?

We hope that you feel free to answer our questions honestly, so that our data will be as complete as possible. There are no right or wrong answers; we just need to know what is true for you and your family based on your experiences. It is important that I read every question, all the way through, for everyone who participates in our project. Since the questions apply to different kinds of families who live in other parts of the country, please wait until I have read all the possible answers before giving me yours, even if your answer was the first one that I read.

NOTE TO INTERVIEWER: ***Coding Refused and Not Applicable Data.***

Throughout the interview, codes for don't know, refused, and not applicable data are available as response options for coding the interview. Do not provide these options to the respondent, but use these should the respondent refuse to answer a question, or if data is not applicable for reasons other than refusal. The not applicable data code should be used to fill in responses when questions are skipped due to skip patterns.

B. Background Information

First, I have some basic background questions for you.

B1. What is your date of birth?
[Code 88/88/88 = Refused]

☐☐/☐☐/☐☐

B2. Are you of Hispanic or Latino origin or background?
○ Yes ○ No ○ Refused

B3. How would you describe your racial background; that is, with which groups do you identify?
[Read each response and mark all that apply]

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or other Pacific Islander
- ○ White or Caucasian
- ○ Other (Specify):_____
- ○ Refused

The next set of questions asks about your household status. *[Read each response]*

B4a. Are you currently married, divorced or separated?

- ○ No (Skip to B4d)
- ○ Married
- ○ Divorced (Skip to B4d)
- ○ Separated (Skip to B4d)
- ○ Refused

b. Is your husband/wife the parent of one or more of the children in the current dependency case?
○ Yes ○ No ○ Refused ○ N/A

c. Are you currently living with your spouse?
○ Yes (Skip to B5) ○ No ○ Refused ○ N/A

d. Are you currently living with a partner?
○ Yes ○ No (Skip to B5) ○ Refused ○ N/A

e. Is your partner male or female?
○ Male ○ Female ○ Refused ○ N/A

f. Is the person you're living with the parent of one or more of the children in the current dependency case?
○ Yes ○ No ○ Refused ○ N/A

B5. How many children do you have? ☐☐
[Code 88 = Refused]

B6. How many of these children are currently living with you? ☐☐ *[Code 88 = Refused]*

B7. Before this child welfare case, had any of your children been placed out of your care?
○ Yes ○ No ○ Refused ○ N/A

Now, I have a few questions to ask about your education, employment status and living situation.

B8a. What is the highest educational degree you have obtained: *[Read each response and mark one]*

- ○ Less than High School, no GED
  What is the highest grade you completed? ☐☐
- ○ High School Diploma or passed GED
- ○ Vocational or trade school certification/degree
- ○ Some vocation or trade school
- ○ Two-year associate degree or some 4-year college
- ○ Four-year college degree or higher
- ○ Refused

b. Are you currently enrolled in any school or training program?
○ Yes ○ No (Skip to B9a) ○ Refused

c. Please tell me what kind of school or training program you're currently enrolled in:
[Mark all that apply]

- ○ High school completion/GED test preparation
- ○ Vocational/trade, or other job training program
- ○ Degree seeking at a community college
- ○ Non-Degree seeking at a community college
- ○ Degree seeking at a 4-year college
- ○ In graduate (post college) school
- ○ Refused
- ○ N/A

B9a. What is your current employment status, (or status to which you will return if you are on maternity/paternity leave): *[Read each response and mark only one]*

- ○ Working full-time (35 or more hours per week)
- ○ Working part-time
- ○ Unemployed or laid off and looking for work
- ○ Unemployed and NOT looking for work
- ○ Full-time homemaker
- ○ Unemployed because in school
- ○ Retired
- ○ Disabled for work
- ○ Refused

b. Are you currently on maternity/paternity leave?
○ Yes ○ No ○ Refused

B10. Do you currently have any of the following health insurance coverage for yourself:	Yes	No	DK	RF
a. Insurance you pay for entirely by yourself	○	○	○	○
b. Employer or union funded [including State employee insurance]	○	○	○	○
c. Government funded including CalWORKS and Medi-Cal	○	○	○	○
d. Retirement Medicare	○	○	○	○
e. Disability Medicare	○	○	○	○

B11. In the past 90 days, have you collected any:	Yes	No	DK	RF
a. Temporary Assistance for Needy Families (TANF), CalWORKS, General Assistance, or any form of welfare	○	○	○	○
b. Food stamps	○	○	○	○
c. Social Security	○	○	○	○
d. Disability	○	○	○	○
e. WIC	○	○	○	○

B12. Where are you currently living? *[Select one]*

- ○ House, mobile home, or apartment
- ○ Residential hotel, rooming house
- ○ Residential treatment facility
- ○ Transitional housing
- ○ Shelter
- ○ Emergency housing
- ○ Homeless
- ○ Jail or prison
- ○ Other: _____
- ○ Refused

B13. Do you have access to:
[Read each response and mark all that apply]

a. Public transportation [bus, subway, etc.]?
○ Yes ○ No ○ Refused

b. A car that you can drive?
○ Yes ○ No ○ Refused

c. Someone who can drive you places if needed?
○ Yes ○ No ○ Refused

Next, we have a few questions regarding your health status. Please remember that anything you tell me will be kept strictly confidential.

B14. Following are different types of medical and other service needs that you may be experiencing. I will not ask you to share any details; please just tell me which apply to you.

a. *[If female]* **Are you currently pregnant?**
○ Yes ○ No ○ Refused ○ N/A

b. Do you currently have any chronic medical problems (for example, asthma, diabetes, HIV/AIDS, Hepatitis, TB, or cancer)?
○ Yes ○ No ○ Refused

c. Are you currently receiving treatment for substance abuse?
○ Yes ○ No ○ Refused

d. Do you consider yourself to be in recovery?
○ Yes ○ No ○ Refused

B15 is asked only of comparison group or SARMS/Tier 1 participants.

B15a. Have you been given the opportunity to enroll in the Dependency Drug Court?

- ○ Yes
- ○ No (Skip to Section C)
- ○ Don't Know (Skip to Section C)
- ○ Refused (Skip to Section C)

b. Why did you decide not to participate in Dependency Drug Court? *[Mark all that apply]*

- ○ Too busy
- ○ Lawyer's advice
- ○ Not interested
- ○ I don't need it
- ○ Other: _____
- ○ Refused
- ○ N/A

C. Substance Use History *[ASI-LITE]*

As you know, this study is focused on understanding the experiences of parents involved with the child welfare system and the alcohol and drug treatment system. Because of this, it's important for us to learn a little bit more from you about your substance use and history. The next questions I have for you ask about your experiences with alcohol and other drugs, your treatment history, and attitudes about treatment. Again, remember that what you tell me today is confidential, and will not be shared with anyone. Some of the following questions ask about your substance use and treatment during the 30 days before the start of your dependency case. That date was *[petition date]***, so 30 days before that would be** *[date]*. **So, we're talking about** *[date]* **to** *[petition date]*.

C1. In the 30 days before the start of your dependency case, how many days were you treated in a residential setting for alcohol or drugs? _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C2. In the 30 days before the start of your dependency case, how many days were you treated in an outpatient setting for alcohol or drugs (including NA,AA)? _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C3. How many times in your life have you been treated for alcohol problems? _____ (0 1 2 3 4 5 6 7 8 9) (0 1 2 3 4 5 6 7 8 9)

C3a. How many of these were 12 Step Programs only? _____ (0 1 2 3 4 5 6 7 8 9) (0 1 2 3 4 5 6 7 8 9)

C4. How many times in your life have you been treated for drug problems? _____ (0 1 2 3 4 5 6 7 8 9) (0 1 2 3 4 5 6 7 8 9)

C4a. How many of these were 12 Step Programs only? _____ (0 1 2 3 4 5 6 7 8 9) (0 1 2 3 4 5 6 7 8 9)

In the 30 days before the start of your dependency case, on how many days did you use each of the following substances?

C5. Alcohol **--** any use at all of beer, wine, liquor, or grain alcohol _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C6. Alcohol **--** to the point where you felt its effects {intoxication} _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C7. Heroin _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C8. Other opiates/analgesics, such as painkillers or Morphine (dilaudid, demoral, percocet, percodan, pantopon, dia-quel, darvon, darvoet, talwin, codeine) _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C9. Barbituates or "downers" (Nembutal, seconal, tuinal, amytal, pentobarbital, secobarbital, phenobarbital, fiorinol, doriden, placidly) _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C10. Other sedatives or tranquilizers (benzodiazepines, valium, Librium, ativan, serax, tranxene, dalmane, halcyon, xanax; phenothiazines, thorazine, stelazine, haldol, navan, senitil, mellaril, prolixin, compazine, miltown; Other: chloranhdrate, tofranil, Quaaludes) _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C11. Cocaine, including Crack _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C12. Amphetamines or Speed (Monster, Crank, Benzedrine, desecrine, ritaline, crystal) _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C13. Cannabis **--** Marijuana or hashish _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)

C14. Hallucinogens, like LSD or mushrooms (mescaline, peyote, green, PCP, angel dust) _____ 0 1 2 3 / 0 1 2 3 4 5 6 7 8 9

C15. Inhalants (nitrous oxide, amyl nitrate, whippets, poppers, glue, solvents) _____ 0 1 2 3 / 0 1 2 3 4 5 6 7 8 9

C16. More than one substance per day (including alcohol) _____ 0 1 2 3 / 0 1 2 3 4 5 6 7 8 9

C17. Any other substances _____ 0 1 2 3 / 0 1 2 3 4 5 6 7 8 9

The next questions refer to your substance use during your lifetime. In your lifetime, how many years did you use each of the following substances regularly? By "regularly" I mean at least 3 times per week for 6 months or more.

C18. Alcohol **--** any use at all of beer, wine, liquor, or grain alcohol _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C19. Alcohol **--** to the point where you felt its effects {intoxication} _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C20. Heroin _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C21. Other opiates/analgesics, such as painkillers or Morphine (dilaudid, demoral, percocet, percodan, pantopon, dia-quel, darvon, darvoet, talwin, codeine) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C22. Barbituates or "downers" (Nembutal, seconal, tuinal, amytal, pentobarbital, secobarbital, phenobarbital, fiorinol, doriden, placidly) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C23. Other sedatives or tranquilizers (benzodiazepines, valium, Librium, ativan, serax, tranxene, dalmane, halcyon, xanax; phenothiazines, thorazine, stelazine, haldol, navan, senitil, mellaril, prolixin, compazine, miltown; Other: chloranhdrate, tofranil, Quaaludes) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C24. Cocaine, including Crack _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C25. Amphetamines or Speed (Monster, Crank, Benzedrine, desecrine, ritaline, crystal) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C26. Cannabis **--** Marijuana or hashish _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C27. Hallucinogens, like LSD or mushrooms (mescaline, peyote, green, PCP, angel dust) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C28. Inhalants (nitrous oxide, amyl nitrate, whippets, poppers, glue, solvents) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C29. More than one substance per day (including alcohol) _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C30. Any other substances _____ 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

C31. Which of these substances has been the major problem? *[Mark all that apply]:*

- O Alcohol - beer, wine, liquor, or grain alcohol
- O Alcohol - to the point where you felt its effects {intoxication}
- O Heroin
- O Other opiates/analgesics, such as painkillers or Morphine (dilaudid, demoral, percocet, percodan, pantopon, dia-quel, darvon, darvoet, talwin, codeine)
- O Barbituates or "downers" (Nembutal, seconal, tuinal, amytal, pentobarbital, secobarbital, phenobarbital, fiorinol, doriden, placidly)
- O Other sedatives or tranquilizers (benzodiazepines, valium, Librium, ativan, serax, tranxene, dalmane, halcyon, xanax; phenothiazines, thorazine, stelazine, haldol, navan, senitil, mellaril, prolixin, compazine, miltown; Other: chloranhdrate, tofranil, Quaaludes)
- O Cocaine, including Crack
- O Amphetamines or Speed (Monster, Crank, Benzedrine, desecrine, ritaline, crystal)
- O Cannabis - Marijuana or hashish
- O Hallucinogens, like LSD or mushrooms (mescaline, peyote, green, PCP, angel dust)
- O Inhalants (nitrous oxide, amyl nitrate, whippets, poppers, glue, solvents)
- O Any other substances

	C32a. Alcohol?	C32b. Drugs?
C32. In the 30 days before the start of your dependency case, how much money would you say you spent on:	$ ____	$ ____

C33. In the 30 days before the start of your dependency case, how many days did you experience:

a. Alcohol problems? _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)
[If 0, skip 34 & 35]

b. Drug problems? _____ (0 1 2 3) (0 1 2 3 4 5 6 7 8 9)
[If 0, skip 36 & 37]

SHOWCARD A
For the following questions, please use the answer choices on this card. The answer choices are not at all, slightly, moderately, considerably, and extremely. *[Give the respondent Show Card A and read all responses for the first two questions.]*

	Not at all	Slightly	Moder-ately	Con-sid-erably	Ex-trem-ely	DK	RF	NA
C34. How troubled or bothered were you by these alcohol problems in the 30 days before the start of your dependency case?	O	O	O	O	O	O	O	O
C35. How important to you now is treatment for these alcohol problems?	O	O	O	O	O	O	O	O
C36. How troubled or bothered were you by these drug problems in the 30 days before the start of your dependency case?	O	O	O	O	O	O	O	O
C37. How important to you now is treatment for these drug problems?	O	O	O	O	O	O	O	O

D. Parental Motivation for Treatment *[TCU]*

SHOWCARD B

The next set of questions asks about how important treatment for drug and alcohol problems is to you now. Please use this card, and tell me if you strongly disagree, disagree, neither agree or disagree, agree, or strongly agree with the following statements. *[Give the respondent Show Card B and read the response choices for the first two items. Ask all items D1-21, and ask D22-29 only if respondent is in treatment (yes to B14c).]*

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	DK	RF	NA
D1. You could be sent to jail or prison if you are not in treatment.	○	○	○	○	○	○	○	○
D2. You feel a lot of pressure to be in treatment.	○	○	○	○	○	○	○	○
D3. You have legal problems that require you to be in treatment.	○	○	○	○	○	○	○	○
D4. You are concerned about legal problems.	○	○	○	○	○	○	○	○
D5. You have family members who want you to be in treatment.	○	○	○	○	○	○	○	○
D6. Your drug use is a problem for you.	○	○	○	○	○	○	○	○
D7. You need help in dealing with your drug use.	○	○	○	○	○	○	○	○
D8. Your drug use is more trouble than it's worth.	○	○	○	○	○	○	○	○
D9. Your drug use is causing problems with the law.	○	○	○	○	○	○	○	○
D10. Your drug use is causing problems in thinking or doing your work.	○	○	○	○	○	○	○	○
D11. It is urgent for you to find help immediately for your drug use.	○	○	○	○	○	○	○	○
D12. Your drug use is causing problems with your family or friends.	○	○	○	○	○	○	○	○
D13. You are tired of the problems caused by drugs.	○	○	○	○	○	○	○	○
D14. Your drug use is causing problems in finding or keeping a job.	○	○	○	○	○	○	○	○
D15. You will give up your friends and hangouts to solve your drug problems.	○	○	○	○	○	○	○	○
D16. You can quit drugs without any help.	○	○	○	○	○	○	○	○
D17. Your drug use is causing problems with your health.	○	○	○	○	○	○	○	○
D18. Your life has gone out of control.	○	○	○	○	○	○	○	○
D19. Your drug use is making your life become worse and worse.	○	○	○	○	○	○	○	○
D20. Your drug use is going to cause your death if you do not quit soon.	○	○	○	○	○	○	○	○
D21. You want to get your life straightened out.	○	○	○	○	○	○	○	○

Ask D22-D29 only of participants who are currently in treatment.

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	DK	RF	NA
D22. You want to be in a drug treatment program.	○	○	○	○	○	○	○	○
D23. You have too many outside responsibilities now to be in treatment.	○	○	○	○	○	○	○	○
D24. This treatment program seems too demanding for you.	○	○	○	○	○	○	○	○
D25. This treatment may be your last chance to solve your drug problems.	○	○	○	○	○	○	○	○
D26. This kind of treatment program will not be very helpful to you.	○	○	○	○	○	○	○	○
D27. You plan to stay in this treatment program for a while.	○	○	○	○	○	○	○	○
D28. You are in this treatment program because someone else made you come.	○	○	○	○	○	○	○	○
D29. This treatment program can really help you.	○	○	○	○	○	○	○	○

E. Parental Perceptions of Treatment Access and Appropriateness *[NPC]*

SHOWCARD C

In next set of questions I will ask you about your experiences getting access to substance abuse treatment since the start of your dependency case. This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, or strongly agree. *[Give the respondent Show Card C and read the response choices for the first two items.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
E1. It has been easy for me to get the substance abuse treatment services I think I need.	○	○	○	○	○	○	○
E2. The substance abuse treatment services I am receiving/I did receive are/were helpful to me.	○	○	○	○	○	○	○
E3. The location of substance abuse treatment services was convenient (for example, parking, public transportation, location, etc.).	○	○	○	○	○	○	○
E4. Overall, I am satisfied with the substance abuse treatment services I have received.	○	○	○	○	○	○	○

F. Social Support for Recovery *[NPC]*

SHOWCARD C

The next set of questions asks about the type of support for recovery you may or may not have in your life. For each question please use this card to tell me if you strongly disagree, disagree, agree, or strongly agree with the statement. *[Use Show Card C and read each response option for the first two items. Skip F5 and F6 if the respondent is not in recovery (no to B14d).]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
F1. My partner/spouse wants me to stay sober.	○	○	○	○	○	○	○
F2. My partner/spouse uses drugs or alcohol.	○	○	○	○	○	○	○
F3. I have other close friends or family members who want me to stay sober.	○	○	○	○	○	○	○
F4. I have other close friends or family members who use drugs or alcohol.	○	○	○	○	○	○	○
F5. My partner/spouse is helping me in my recovery.	○	○	○	○	○	○	○
F6. I have other close friends or family members that help me in my recovery.	○	○	○	○	○	○	○

G. Service Delivery *[NPC]*

SHOWCARD D & E

Now I'd like to talk with you about services you may or may not be receiving. As I read down the list, please tell me whether you needed the following services in the past 30 days. This would be from _____ (date) **up to today. If you have received more than one of this type of service, please tell me about your most recent experience.**

	a. Have you needed _____ *[service]* in the past 30 days?		**b.** *[If yes to a],* **Did you obtain the service?**		**c.** *[If yes to b],* **Who helped you get this service?** *[Use Show Card D]* *[Mark all that apply]*	**d.** *[If yes to b],* **How helpful was the service?** *[Use Show Card E]*
	Yes	No	Yes	No	1=SARMS or Drug Court Recovery Specialist 2=Dependency Drug Court or Juvenile Court Judge 3=Attorney 4=CWS caseworker 5=Treatment provider or counselor 6=Other 7=No one	1= Not at all helpful 2=A little helpful 3=Very helpful 4=Extremely helpful
G1. Help with transportation	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G2. Help with housing	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④

	a. Have you needed _____ [service] in the past 30 days?		b. [If yes to a], Did you obtain the service?		c. [If yes to b], Who helped you get this service? [Use Show Card D] [Mark all that apply] 1=SARMS or Drug Court Recovery Specialist 2=Dependency Drug Court or Juvenile Court Judge 3=Attorney 4=CWS caseworker 5=Treatment provider or counselor 6=Other 7=No one	d. [If yes to b], How helpful was the service? [Use Show Card E] 1= Not at all helpful 2=A little helpful 3=Very helpful 4=Extremely helpful
	Yes	No	Yes	No		
G3. Help getting health insurance	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G4. Help/services for your children, such as counseling or medical services	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G5. Parenting classes	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G6. Childcare	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G7. Help finding employment	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G8. Financial assistance	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G9. Mental health services	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G10. Substance abuse assessment	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G11. Substance abuse treatment services	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G12. Domestic violence services	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G13. Medical services/ medication	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G14. Relationship or marital counseling	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G15. Family Unity Meetings	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④
G16. SARMSWrap Services (also called SARMS Wraparound Aftercare Services	○	○	○	○	① ② ③ ④ ⑤ ⑥ ⑦	① ② ③ ④

H. Intervention Frequency *[NPC]*

These next questions ask about the court appearances and other appointments that you have had recently.

H1. Are you still involved with _____ *[name of drug court for treatment sample, name of child welfare court for comparison sample]?* ○ Yes ○ No ○ DK ○ RF ○ NA

[If yes to H1]: **Please answer the following questions based on the court appearances and activities you have had in the past month.**
[If no to H1]: **Please answer the following questions based on the court activities you had in the last month of your case.**

SHOWCARD F
This card will help you choose your answer to each question. The answer choices, as shown on this card, are never, once during the past month, 2 to 3 times, once a week, or more than once a week. *[Give the respondent the Show Card F and read the response choices for the first two items.]*

[If yes to H1]: **Please tell me how often during the past month you have:**
[If no to H1]: **Please tell me how often in the last month of your case you have:**

	Never	Once	2-3 times	Once a week	More than once a week	DK	RF	NA
H2. Appeared in court for this child welfare case?	○	○	○	○	○	○	○	○
H3. Had a urinalysis (UA, or urine test to check for substance use)?	○	○	○	○	○	○	○	○
H4. Met with or spoken to your child welfare caseworker?	○	○	○	○	○	○	○	○
H5. Met with or spoken to your attorney?	○	○	○	○	○	○	○	○
H6. Met with or spoken with a substance abuse treatment counselor?	○	○	○	○	○	○	○	○
H7. Met with or spoken with a case manager, Recovery Specialist, or someone besides your child welfare caseworker who is helping you with your child welfare plan?	○	○	○	○	○	○	○	○

I. Quality of Relationships *[NPC]*

SHOWCARD C
[Note to interviewer: If the answer to H1 was "no", skip to Section K.]
Now I'd like to ask you about how you're feeling about your relationships with people in the court, child welfare, and treatment systems. This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, and strongly agree. *[Give the respondent Show Card C and read each response option for the first two questions. Ask I15-18 only of those people in drug court/SARMS.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
I1. The judge cares about what happens to me.	○	○	○	○	○	○	○
I2. The judge is knowledgeable about my case.	○	○	○	○	○	○	○
I3. The judge explains to me what I need to do to get or keep custody of my child[ren].	○	○	○	○	○	○	○
I4. The judge helps me get what I need ("goes to bat" for me).	○	○	○	○	○	○	○
I5. My child welfare case worker cares about what happens to me.	○	○	○	○	○	○	○
I6. My child welfare case worker is knowledgeable about my case.	○	○	○	○	○	○	○
I7. My child welfare case worker explains to me what I need to do to get or keep custody of my child[ren].	○	○	○	○	○	○	○
I8. My child welfare case worker helps me get what I need ("goes to bat" for me).	○	○	○	○	○	○	○
I9. My treatment counselor cares about what happens to me.	○	○	○	○	○	○	○
I10. My treatment counselor is knowledgeable about my case.	○	○	○	○	○	○	○
I11. My treatment counselor explains to me what I need to do to get or keep custody of my child[ren].	○	○	○	○	○	○	○
I12. My treatment counselor helps me get what I need ("goes to bat" for me).	○	○	○	○	○	○	○
I13. There is a team of people helping me with my case.	○	○	○	○	○	○	○
I14. I know several professionals I can turn to if I need help or advice.	○	○	○	○	○	○	○

Questions I15-I18 are for drug court/SARMS clients only.

I15. The SARMS or Drug Court Recovery Specialist cares about what happens to me.	○	○	○	○	○	○	○
I16. The SARMS or Drug Court Recovery Specialist is knowledgeable about my case.	○	○	○	○	○	○	○
I17. The SARMS or Drug Court Recovery Specialist explains to me what I need to do to get or keep custody of my child[ren].	○	○	○	○	○	○	○
I18. The SARMS or Drug Court Recovery Specialist helps me get what I need ("goes to bat" for me).	○	○	○	○	○	○	○

J. Understanding of ASFA/Child Welfare Process

[Note to interviewer: If the answer to H1 was "no", skip to Section K.]
Now I have a few questions about how you're feeling about your experiences with the child welfare system.

J1. Are any of your children currently in a court-ordered out of home placement? ○ Yes ○ No ○ RF

J2. Are any of your children currently living with you? ○ Yes ○ No ○ RF

SHOWCARD C
This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, or strongly agree *[Provide Show Card C and read each response option for each question. Ask J3-4 of all parents, J5-7 only of parents who have had at least one child removed, and J8-9 only of parents who have at least one child at home.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
[Ask of all parents:]							
J3. I understand that I have a limited time to complete my child welfare service plan.	○	○	○	○	○	○	○
J4. I am concerned that I won't have time to complete everything in my child welfare service plan.	○	○	○	○	○	○	○
[Ask only of parents who have had at least one child removed:]							
J5. I am worried that I may not regain custody of my child[ren].	○	○	○	○	○	○	○
J6. I have a clear understanding about what I need to do to have my child[ren] returned to me.	○	○	○	○	○	○	○
J7. I am confused about what is happening with my child[ren].	○	○	○	○	○	○	○
[Ask only of parents who have at least one child at home:]							
J8. I am worried that I will lose custody of my child[ren].	○	○	○	○	○	○	○
J9. I have a clear understanding about what I need to do to complete my child welfare service plan.	○	○	○	○	○	○	○

K. Perceived Stress *[PSS]*

SHOWCARD G
The next group of questions asks about some things you may have felt in the past month. This card will help you choose your answer to each question. The answer choices, as shown on this card are, never, almost never, sometimes, fairly often or very often. *[Give respondent Show Card G and read each response option for the first two questions.]*

	Never	Almost Never	Some-times	Fairly Often	Very Often	DK	RF
K1. In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○	○	○
K2. In the last month, how often have you felt that you were confident about your ability to handle personal problems?	○	○	○	○	○	○	○
K3. In the last month, how often have you felt that things were going your way?	○	○	○	○	○	○	○
K4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○	○	○

L. Parents' Perceptions of Control *(FES)*

SHOWCARD G

The next set of questions asks about ways people handle difficult issues in their life. These questions are asking in general how you feel right now. The answer choices, as shown on this card, are never, almost never, sometimes, fairly often, and very often. Answer these questions by thinking about in general how you feel right now. *[Provide Show Card G and read each response option for the first two questions.]*

	Never	Almost Never	Some-times	Fairly Often	Very Often	DK	RF	NA
L1. When problems arise in my life, I handle them pretty well.	○	○	○	○	○	○	○	○
L2. I am able to work with agencies and professionals to decide what services my family needs.	○	○	○	○	○	○	○	○
L3. When I am not sure about what I need to do, I know how to get that information.	○	○	○	○	○	○	○	○
L4. I am able to get information I need about what is happening with my child[ren].	○	○	○	○	○	○	○	○
L5. I am able to get information I need about what I need to do to complete my case plan.	○	○	○	○	○	○	○	○
L6. I just can't cope with all the things I need to do for myself and my family.	○	○	○	○	○	○	○	○
L7. I feel confident that I can do what I need to do to complete my case plan.	○	○	○	○	○	○	○	○

M. Parenting Skills *(AAPI)*

SHOWCARD H

The next set of questions asks about different views of parenting. This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, uncertain, agree, and strongly agree. *[Provide Show Card H and read each response option for the first two questions.]*

	Strongly Disagree	Disagree	Un-certain	Agree	Strongly Agree	DK	RF
M1. Children should keep their feelings to themselves.	○	○	○	○	○	○	○
M2. Spanking teaches children right from wrong.	○	○	○	○	○	○	○
M3. The sooner children learn to feed and dress themselves and use the toilet, the better off they will be as adults.	○	○	○	○	○	○	○
M4. A certain amount of fear is necessary for children to respect their parents.	○	○	○	○	○	○	○
M5. Children should know what their parents need without being told.	○	○	○	○	○	○	○
M6. It is OK to spank as a last resort.	○	○	○	○	○	○	○
M7. "Because I said so!" is the only reason parents need to give.	○	○	○	○	○	○	○
M8. Time-out is an effective way to discipline children.	○	○	○	○	○	○	○
M9. Children have a responsibility to please their parents.	○	○	○	○	○	○	○
M10. Sometimes spanking is the only thing that will work.	○	○	○	○	○	○	○
M11. There is nothing worse than a strong-willed two year old.	○	○	○	○	○	○	○
M12 Children can learn good discipline without being spanked.	○	○	○	○	○	○	○
M13. Children who feel secure often grow up expecting too much.	○	○	○	○	○	○	○
M14. A good spanking lets children know parents mean business.	○	○	○	○	○	○	○
M15. Babies need to learn how to be considerate of the needs of their mother.	○	○	○	○	○	○	○
M16. Spanking teaches children it's alright to hit others.	○	○	○	○	○	○	○
M17. Letting a child sleep in the parent's bed every now and then is a bad idea.	○	○	○	○	○	○	○
M18. Children need discipline, not spanking.	○	○	○	○	○	○	○
M19. A good child sleeps through the night.	○	○	○	○	○	○	○
M20. Hitting a child out of love is different than hitting a child out of anger.	○	○	○	○	○	○	○
M21. A good spanking never hurt anyone.	○	○	○	○	○	○	○

N. Visitation *[NPC]*

The next questions are about your interactions with *[Target Child]*. *[Target Child is identified on cover sheet]*

N1. Since your child welfare case began, has *[Target Child]* been in court-ordered out of home placement for more than 30 days in a row? ○ Yes ○ No (Skip to Section O) ○ Refused

N2. Is *[Target Child]* currently in court-ordered out of home placement? ○ Yes (Go to N3, then Skip to N5) ○ No (Skip to N4) ○ Refused ○ NA

N3. Now I have some questions about visitations you may have had. For the purpose of this interview, please think about your visits with *[Target Child]* when you are answering these questions.

	0	1	2	3	4 or more	DK	RF	NA
N3a. In the past 30 days, how many visits were scheduled with *[Target Child]*?	○	○	○	○	○	○	○	○
N3b. In the past 30 days how many visits have you had with *[Target Child]*?	○	○	○	○	○	○	○	○
N3c. In the past 30 days how often have your visits with *[Target Child]* been cancelled or rescheduled by your caseworker (or whoever schedules your visits)?	○	○	○	○	○	○	○	○
N3d. In the past 30 days how often have you missed a scheduled visit with *[Target Child]* for other reasons?	○	○	○	○	○	○	○	○

[Go to N5]

N4. Now I have some questions about visitations you may have had. For purposes of this interview, please think about your visits with *[Target Child]* when you are answering these questions.

	0	1	2	3	4 or more	DK	RF	NA
N4a. In the month before the child returned home, how many visits were scheduled with *[Target Child]*?	○	○	○	○	○	○	○	○
N4b. In the month before the child returned home, how many visits have you had with *[Target Child]*?	○	○	○	○	○	○	○	○
N4c. In the month before the child returned home, how often have your visits with *[Target Child]* been cancelled or rescheduled by your case worker (or whoever schedules your visits)?	○	○	○	○	○	○	○	○
N4d. In the month before the child returned home, how often have you missed a scheduled visit with *[Target Child]* for other reasons?	○	○	○	○	○	○	○	○

SHOWCARD C

N5. Think about the last visit you had with *[Target Child]***. To what extent do the following describe how you felt during the visit? This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, or strongly agree.** *[Provide Show Card C and read each response option for the first two questions.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
a. I was happy.	○	○	○	○	○	○	○
b. I was sad.	○	○	○	○	○	○	○
c. I was anxious or stressed.	○	○	○	○	○	○	○
d. Things went smoothly during the visit.	○	○	○	○	○	○	○
e. I was being a good parent.	○	○	○	○	○	○	○
f. I was emotionally connected with my child.	○	○	○	○	○	○	○
g. My child was misbehaving.	○	○	○	○	○	○	○
h. I was worried about my child.	○	○	○	○	○	○	○
i. I felt that *[Target Child]* would be better off not seeing me.	○	○	○	○	○	○	○

Now, please answer Yes or No to the following:	Yes	No	DK	RF	NA
j. I thought about using drugs or alcohol before the visit.	○	○	○	○	○
k. I did use drugs or alcohol before the visit.	○	○	○	○	○
l. I thought about using drugs or alcohol after the visit.	○	○	○	○	○
m. I did use drugs or alcohol after the visit.	○	○	○	○	○

SHOWCARD C

N6. Think about the last visit you had with *[Target Child]***. To what extent do the following describe how you think** *[Target Child]* **felt during the visit? This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, or strongly agree.** *[Provide Show Card C and read each response option for the first two questions.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
a. S/he was happy.	○	○	○	○	○	○	○
b. S/he was sad.	○	○	○	○	○	○	○
c. S/he was anxious or stressed.	○	○	○	○	○	○	○
d. S/he acted "cool" or distant from me.	○	○	○	○	○	○	○

N7. On average, across your entire child welfare case, about how many times each month did/do you usually have visits with *[Target Child]***?**

- O Less than once per month
- O Once per month
- O 2-3 times per month
- O Weekly
- O More than once per week
- O DK
- O RF
- O NA

O. Parental Perceptions of Child Well-Being *(SSRS [Elliot, et. al. 1988])*

SHOWCARD C

Now I have a few more questions about your son/daughter, *[Target Child].* **This card will help you choose your answer to each question. The answer choices, as shown on this card, are strongly disagree, disagree, agree, or strongly agree.** *[Give respondent Show Card C and read each response option for the first two questions.]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	DK	RF	NA
O1. My child has received the services she/he needs.	O	O	O	O	O	O	O
O2. My child is well cared for in her/his current living situation. *[Code N/A if child at home]*	O	O	O	O	O	O	O
O3. My child is safe in his/her current living situation. *[Code N/A if child at home]*	O	O	O	O	O	O	O

O4a. Is your child receiving any services for behavioral, emotional, or school-related problems?

- O Yes
- O No [Skip to O5]
- O On waiting list, services pending [Skip to O5]
- O Don't Know [Skip to O5]
- O Refused

O4b. How satisfied are you with the services that your child is receiving?

- O Very Satisfied
- O Somewhat Satisfied
- O Dissatisfied
- O Very Dissatisfied
- O Don't Know
- O Refused
- O NA

SHOWCARD I

[Skip O5-O21 if target child is under the age of 2, or participant indicates that she/he has not seen target child in the last 30 days (answer to N3b=0).] **Sometimes children experience behavioral or other problems. Please indicate whether you think** *[Target Child]* **has experienced any of the following during the last month. This card will help you choose your answer to each question. The answer choices, as shown on this card, are not true, somewhat or sometimes true, and very true or often true.** *[Provide Show Card I and read each response option for the first two questions.]*

_____ *[Target Child]:*	Not True	Somewhat or Sometimes True	Very True or Often True	DK	RF	NA
O5. Hits and fights with other children.	O	O	O	O	O	O
O6. Is unhappy, sad, or depressed.	O	O	O	O	O	O
O7. Doesn't get along with other kids.	O	O	O	O	O	O

	Not True	Somewhat or Sometimes True	Very True or Often True	DK	RF	NA
O8. Acts too young for his/her age.	○	○	○	○	○	○
O9. Is disobedient at home *[or foster home]*.	○	○	○	○	○	○
O10. Is nervous, high-strung, or tense.	○	○	○	○	○	○
O11. Feels worthless or inferior.	○	○	○	○	○	○
O12. Is restless and fidgets a lot.	○	○	○	○	○	○
O13. Has temper tantrums or a hot temper.	○	○	○	○	○	○
O14. Worries about things for a long time.	○	○	○	○	○	○
O15. Makes friends easily.	○	○	○	○	○	○
O16. Enjoys learning.	○	○	○	○	○	○
O17. Likes to try new things.	○	○	○	○	○	○
O18. Comforts or helps others.	○	○	○	○	○	○
O19. Accepts friends' ideas in sharing and playing.	○	○	○	○	○	○
O20. Wants to hear that he or she is doing okay.	○	○	○	○	○	○
O21. Makes changes from one activity to another with difficulty	○	○	○	○	○	○

P. Social Support *(ISEL)*

SHOWCARD J

The next set of questions asks about the type of other support you may or may not have in your life. This card will help you choose your answer to each question. The answer choices, as shown on this card, are definitely false, probably false, probably true, or definitely true. *[Give respondent Show Card J and read all the response options for the first two questions.]*

	Definitely False	Probably False	Probably True	Definitely True	DK	RF
P1. When I need suggestions for how to deal with a personal problem, I know someone I can turn to.	○	○	○	○	○	○
P2. I feel like there is no one with whom I can share my most private worries and fears.	○	○	○	○	○	○
P3. I know several people that I enjoy spending time with.	○	○	○	○	○	○

	Definitely False	Probably False	Probably True	Definitely True	DK	RF
P4. I don't often get invited to do things with other people.	○	○	○	○	○	○
P5. When I feel lonely, there are several people I can talk to.	○	○	○	○	○	○
P6. I regularly meet or talk with members of my family or with friends.	○	○	○	○	○	○
P7. There is someone I can turn to for advice about handling problems with my family.	○	○	○	○	○	○
P8. If a family crisis arose, it would be difficult for me to find someone who could give me good advice about how to handle it.	○	○	○	○	○	○
P9. If I needed to borrow $25, there is someone I could turn to.	○	○	○	○	○	○
P10. If I were sick, I could easily find someone to help me with my daily chores.	○	○	○	○	○	○
P11. If I was stranded 10 miles from home, there is someone I could call who could come and get me.	○	○	○	○	○	○
P12. If I needed help in moving to a new house or apartment, I would have a hard time finding someone to help me.	○	○	○	○	○	○

Q. Psychiatric Status *[ASI-LITE]*

This next set of questions asks about some emotional or psychological states you may have experienced in the past 30 days and in your lifetime.

Q1. How many times in your lifetime have you been treated for any psychological or emotional problems:

a. In a hospital or inpatient setting? ☐☐ **b. As an outpatient/private patient?** ☐☐

Q2. Do you receive a pension for a psychiatric disability? ○ Yes ○ No ○ Don't Know ○ Refused

Q3. Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:	In the past 30 days? Y	N	RF	In your lifetime? Y	N	RF
a. Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function	○	○	○	○	○	○
b. Experienced serious anxiety/tension, felt uptight, unreasonably worried, unable to feel relaxed	○	○	○	○	○	○
c. Experienced hallucinations-saw things or heard voices that were not there	○	○	○	○	○	○
d. Experienced trouble understanding, concentrating, or remembering	○	○	○	○	○	○
Have you had a significant period of time (that may or may *not* have been a direct result of alcohol/drug use) in which you have:						
e. Experienced trouble controlling violent behavior, including episodes of rage or violence	○	○	○	○	○	○
f. Experienced serious thoughts of suicide	○	○	○	○	○	○
g. Attempted suicide	○	○	○	○	○	○
h. Been prescribed medication for any psychological or emotional problems	○	○	○	○	○	○

[Note to interviewer: If participant answers no to Q3a-h, skip to Section R]

Q4. For how many days in the past month have you experienced any of these psychological or emotional problems? ☐☐

SHOWCARD A

For the following questions, please use the answer choices on this card. The answer choices are not at all, slightly, moderately, considerably, and extremely. *[Give the respondent Show Card A and read all responses for these questions.]*

	Not at all	Slightly	Moder-ately	Con-sid-erably	Ex-trem-ely	DK	RF	NA
Q5. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?	○	○	○	○	○	○	○	○
Q6. How important to you *now* is treatment for these psychological or emotional problems?	○	○	○	○	○	○	○	○

R. Closing *[NPC]*

Now that we have completed these specific questions, I would like to ask you some general questions about your experiences related to your case.

[Ask this question of SARMS/Tier 1/drug court participants only.]
R1. Are you still participating in *[SARMS/Tier 1/drug court]***? If not, why not?**

R2. What, if anything, did you find was the biggest barrier to making progress on your case plan?

R3. Is there anything you would like to say about this interviewing experience, or any suggestions regarding this interview that you'd like to mention?

R4. Is there anything else you want to tell me?

Thank you very much for your time today, and answering all these questions. Your participation in this study is greatly appreciated. Without you this study would not be possible.

Complete the incentive receipt and deliver the incentive.

End Time:_____

Interview Debriefing

After the interview please take a moment to answer the following questions about how the interview went.

1. To what extent were there distractions, interruptions, or other disruptions in the interview today? If yes, describe.

   ○ A lot ○ Somewhat ○ A little ○ Not at all

2. To what extent was the respondent actively engaged (attentive, interested, not answering "by rote") in the interview process?

   ○ A lot ○ Somewhat ○ A little ○ Not at all

3. Were there other individuals present or within earshot for some or all of the interview? If yes, describe.

   ○ Yes ○ No

4. If yes, to what extent do you think this inhibited the participants' responses to these questions?

   ○ A lot ○ Somewhat ○ A little ○ Not at all

5. To what extent was the respondent comfortable with the interview? If not, why?

   ○ A lot ○ Somewhat ○ A little ○ Not at all

6. Anything else that we should know about the interview or circumstances surrounding the interview?

APPENDIX C: OPERATIONAL DEFINITIONS

Characteristic	Level of Analysis	Operational Definition
i. Demographics		
Race	Parent	Check all that apply variable and separate Hispanic variable
Gender	Parent	No variable for this—if P1, Section I is filled out it's a mother; if P1, Section II is filled out, it's a father
Age	Parent	Calculate from the date of birth to earliest petition date
Education Level	Parent	
Employment Status	Parent	
Marital Status	Parent	
ii. Substance Use		
Drug of choice	Parent	Selected tx episode closest to the petition date (could have started before or after petition date) & took primary drug as reported
Previous treatment	Parent	Counted all tx episodes that occurred within 2 yrs prior to petition date (either started within those 2 yrs or was ongoing at the start of the pre-2yr window)
Age of first use	Parent	Selected tx episode closest to the petition date (could have started before or after petition date) & took age of first use of primary drug
Frequency of use	Parent	Selected tx episode closest to the petition date (could have started before or after petition date) & took frequency of use of primary drug
iii. Child Welfare		
Number of children in case	Parent	No variable for this—tally the children listed on P1, IVA1 (Counted number of birthdates and double checked with number of names)
Ages of children	Parent	Calculate from DOB and earliest petition date for the family
Children's risk factors	Parent	At least 1 child had each of the risk factors (y/n) Cumulative risk – sum of whether or not at least 1 child had each risk factor
Parent risk factors	Parent	Whether or not each parent had a particular risk factor (y/n) Cumulative risk – sum of the number of risk factors that each parent had
Previous CPS investigations	Parent	dichotomized

Allegations	Parent	Whether at least 1 child had a particular allegation collapsed into 4 categories: physical, emotional, neglect (neglect, no provision of support, sibling abuse), other (sexual, death, cruelty, other). Other was used only if there were no other types of allegations reported.

Research Question	Level of Analysis	Operational Definition
i. Treatment		
1. Treatment Access		
a. Do drug court system parents enter treatment more quickly?	Parent	Comparison of the drug court system group and comparison group on: 1. Average number of days from petition to treatment entry Note: Those people who enter treatment *prior* to petition will be excluded from this analysis. 2. Average number of days from entry into drug court system to treatment entry Note: This analysis is for the drug court system sample only; those people who enter treatment *prior* to drug court system entry will be excluded from this analysis.
b. Do drug court system parents enter substance abuse treatment at a higher rate?	Parent	Comparison of the drug court system group and comparison group on: 1. Percent who enter outpatient or residential treatment 2. Number of outpatient or residential treatment entries
2. Treatment Experience		
a. Do drug court system parents spend more days in treatment?	Parent	Comparison of drug court system and the comparison group on: 1. Average total days in treatment during the case, defined as the sum of number of days for all episodes (non overlapping days) 2. Total days in each type of treatment, using the following treatment types: outpatient/ intensive outpatient, short & long term residential *Note*: Those who did not enter tx (or a particular type of tx) were assigned '0'
b. Are drug court system parents more likely to complete treatment during the case?	Parent	Comparison of the drug court system and comparison groups on: 1. At least one treatment was completed, defined by exit status of "completed treatment", calculated for all parents (those who didn't enter treatment were assigned a '0' or NO) 2. At least one treatment was completed, defined by exit status of "completed treatment", calculated only for those parents who entered treatment

Research Question	Level of Analysis	Operational Definition
c. Toxicology screens	Parent	Descriptives only 1. at least 1 positive tox screens 0-12mo after petition 2. at least l positive tox screens 12-18mo after petition 3. at least 1 positive tox screens 18-24mo after petition
3. Treatment Recidivism		
a. Are drug court system parents more likely to enter treatment after their CW case is closed?	Parent	Comparison of drug court system and the comparison group on % of parents who had a subsequent treatment entry – cases that were closed for all children only
ii. Child Welfare		
1. Service Access for Children		
a. Are drug court system children more likely to receive services to address their needs?	Child	Comparison of drug court system group to comparison group on: 1. The number of services recommended and received by each child
2. Children's Living Situation Experiences		
a. Do drug court system children have fewer changes in living situation?	Child	Comparison of the drug court system group and comparison groups on: 1. The number of living situation changes. We will define living situation in two ways: a. All living situation changes, whether or not they are considered a placement change by CPS or whether or not they are court-ordered changes b. Number of legal custody changes (Suffolk only)
b. Do drug court system children spend less time in out-of-home placements?	Child	Comparison of the drug court system group and comparison groups on: 1. Number of days each child spent out of the care of original parents on case 2. Percent of time each child spent out of the care of the original parent on the case
c. Are kinship placements used more often in drug court system cases?	Child	Comparison of drug court system group and comparison group: 1. Number of days spent in kinship placements 2. Percent of case spent in a kinship placement Kinship in Washoe, San Diego, and Santa Clara is defined as parent, step-parent, partner of parent, grandparent, aunt, uncle, or other relative (up to third generation). In California there also is a second definition of kinship: "non-related extended family member." In Suffolk kinship is defined as blood relative only. <u>Note:</u> Parents whose children are not removed from the home will be excluded from this analysis.
3. Permanency Outcomes		

Research Question	Level of Analysis	Operational Definition
a. Is time to permanency different between drug court system families and comparison families?	Child	Comparison of the drug court system group with the comparison group on: 1. Average number of days from petition to permanent placement
b. Are reunifications achieved more often?	Child	Comparison of the drug court system group and comparison group on: 1. Child reunified
c. Are TPRs less frequent?	Child	Comparison of the drug court system group and comparison group on: 1. Child had parent tpr'd
d. Is it more common for kin to have custody of children at the end of the case?	Child	Comparison of the drug court system and comparison groups on: 1. Child had permanent kinship placements See definition of kinship in Question IIA1.
e. Are there differences in the frequency of other types of permanency decisions?	Child	Depending on sample size, comparison of drug court system vs. comparison group on: 1. The percent of children with each type of permanency decision: 1. Guardianship (fit and willing relative in Suffolk) 2. Long-term foster care, (not a permanency option for Suffolk; called "alternate plan permanent living arrangement in San Diego) 3. Residential care 4. Emancipated **5.** Juvenile facility
4. Child Welfare Recidivism		
A. Are drug court system parents more likely to have had a second petition on at least 1 child during their case?	Parent	Comparison of drug court system and comparison groups on: 1. whether they had at least 1 child with a second petition during their case
b. Do drug court system parents have fewer substantiated referrals to CPS?	Parent	Comparison of the drug court system and comparison groups on: 1. whether they had a substantiated referral to CPS sometime after petition
c. Do drug court system parents and children have fewer new family/dependency court cases?	Parent	Comparison of the drug court system and comparison groups on: a. whether parent had a subsequent CPS case (petition) *Note*: Closed cases only (all children's cases closed) unless one child in the family had a closed case & there was a subsequent petition
d. Do drug court system children have fewer subsequent out of home placements?	Parent	Comparison of the drug court system and comparison groups on: 1. whether there was at least 1 subsequent out of home placement *Note*: Closed cases only (all children's cases closed) unless one child in the family had a closed case & there was a subsequent out-of-home placement

Research Question	Level of Analysis	Operational Definition
e. Do drug court system parents and children have fewer subsequent terminations of parental rights?	Parent	Comparison of the drug court system group and comparison groups on: 1. Percent of parents with at least one TPR *Note*: Closed cases only (all children's cases closed) unless one child in the family had a closed case & there was a subsequent TPR
f. Do drug court system parents and children have fewer new children with positive toxicology screens at birth?	Parent	Comparison of the drug court system group and comparison groups on: 1. Where there was at least 1 child born with pos tox sometime after case inception *Note*: Only people who had a new child born during case
iii. Court Service Delivery		
1. Contested hearings		
A. Are drug court system parents less likely to have contested hearings?	Parent	Comparison of the drug court system group and comparison group on: 1. Whether there was at least 1 hearing contested
2. Service Order Compliance		
A. Do parents in drug court system cases have greater service order compliance? Descriptive only	Parent	1. # of CW hearings 2. Proportion of hearings that were modified 3. Whether there was indication that court orders were modified due to progress/good behavior 4. Whether there was an indication that court orders were modified due to noncompliant behavior 5. Whether there was an indication that parent was noncompliant with treatment 6. Whether there was an indication that parent was noncompliant with visitation 7. # legal sanctions due to noncompliance (SARMS/Tier1/DC only) Note: These data will be interpreted with caution due to the fact that drug court system participants may be under closer scrutiny than non-participants.
3. Court Case Length		
A. Is the time to drug court system court case closure shorter?	Case	Comparison of the drug court system group and comparison group on: 1. The average number of days from petition to court case closure *Note*: Includes only those cases in which all children's court cases were closed
4. Progress in Drug Court		
A. Time from petition to drug court entry	Parent	Number of days from petition to SARMS or DC entry – descriptive for DC &/or SARMS parents only If parents in SARMS & DC, SARMS date comes first; otherwise, DC date Petition date is first petition date among all children in family

Research Question	Level of Analysis	Operational Definition
B. Total number of days spent in SARMS	Parent	Total number of days spent in SARMS – if SARMS episodes overlapped, removed the overlapping days from total
C. Total number of days spent in drug court	Parent	Total number of days spent in DC – could have 1 or 2 episodes – if DC episodes overlapped, removed the overlapping days from the total
D. Total number of SARMS episodes	Parent	Total number of SARMS episodes (counted SARMS entry dates)
E. Total number of DC episodes	Parent	Total number of DC episodes (1 or 2) (counted # of DC graduation status)
F. Drug court graduation status	Parent	IF there were 2 episodes, we took status of last one
G. Number of DC appearances	Parent	# DC appearances summed across all time periods (0-12, 12-18, and 18-24 after petition)

APPENDIX D: OUTCOME RESULTS DETAIL

OUTCOME RESULTS – DETAIL FROM CHAPTER 3 OF MAIN REPORT

Table D1. Treatment Entry

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent entering treatment during the case								
%	60%	67%	86%	60%	83%	61%	73%	61%
n	438	205	100	553	117	239	84	127
F	4.0		**64.7***		**23.84***		3.65	
Days to treatment entry								
mean	107	101	110	120	58	133	84	114
n	243	121	77	291	82	117	54	69
F	0.2		.6		**21.3***		3.2	

* Statistically significant at p<.001.

Table D2. Time Spent in Treatment

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Days spent in treatment during the case								
Mean	179	154	298	135	297	172	330	132
n	437	205	100	553	117	239	84	127
F	2.4		**115.2***		**29.5***		**43.9***	

* Statistically significant at p<.001.

Table D3. Treatment Graduation

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent of mothers completing at least one treatment during the case (all parents)								
%	31%	40%	69%	32%	61%	32%	62%	37%
n	365	184	83	511	95	201	70	111
F	4.7		**89.4*****		**27.4*****		**12.2****	
Percent of mothers completing at least one treatment during the case (only parents who entered treatment)								
%	59%	62%	82%	57%	76%	60%	91%	67%
n	197	112	68	286	78	105	44	41
F	0.3		**28.3*****		**5.1***		**10.4****	

* Statistically significant at p<.05. **Statistically significant at p<.01. ***Statistically significant at p<.001.

Table D4. Days to Permanent Placement

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Mean	286	255	347	242	216	162	277	262
n	598	359	180	955	63	136	131	179
F	2.7		**29.4***		2.2		0.3	

*Statistically significant at p<.001.

Table D5. Permanency Outcomes

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Percent of children reunified								
%	56%	45%	76%	44%	57%	55%	91%	45%
n	662	393	185	1,001	85	238	144	216
F	**6.3***		**41.6*****		0.1		**53.9*****	
Percent of children with parental rights terminated								
%	24%	28%	11%	34%	8%	11%	3%	34%
n	662	393	185	1,001	85	238	144	216
F	1.2		**24.8*****		0.4		**30.5*****	
Percent of children with another permanency outcome (e.g. long term foster care, emancipation, guardianship)								
%	20%	27%	13%	22%	35%	35%	5%	20%
n	662	393	185	1,001	85	238	144	216
F	**3.9***		**5.8***		0		**10.4****	

* Statistically significant at p<.05. **Statistically significant at p<.01. ***Statistically significant at p<.001.

Table D6. Time to Case Closure

	San Diego		Santa Clara		Suffolk		Washoe	
	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison	FTDC	Comparison
Days to case closure								
Mean	541	466	603	514	563	466	572	439
n	165	69	41	202	29	96	58	49
F	**16.8***		**40.1***		**17.0***		**27.8***	

*Significantly different at p<.001.

APPENDIX E: OUTCOMES FOR SARMS AND DRUG COURT MOTHERS IN SAN DIEGO

Table E1. Treatment Outcomes

	SARMS	Drug Court
Percent entering treatment during case		
percent	59%	71%
n	334	104
Time to treatment entry		
mean	87 days	91 days
n	177	66
Time spent in treatment during case		
mean	117	232
n	333	104
Percent of mothers completing at least one treatment (all parents)		
percent		
n	31%	32%
	280	85
Percent of mothers completing at least one treatment (parents entering treatment only)		
percent	61%	49%
n	142	55

Table E2. Children's Services

	SARMS	Drug Court
Number of children's services during case		
mean	1.4	1.4
n	593	195

Table E3. Children's Living Situations

	SARMS	Drug Court
Number of children's living situations during case		
mean	3.3	3.3
n	633	211
Number of days spent in parental care		
mean	162	91
n	596	192
Percent of the case spent in parental care		
mean	29%	15%
n	596	192
Number of days spent in out-of-home placements		
mean	460	558
n	613	204
Percent of case spent in out-of-home placements		
mean	71%	52%
n	606	204
Number of days spent in kinship care placements		
mean	245	274
n	615	204
Percent of case spent in kinship care placements		
mean	38%	41%
n	613	204
Number of days spent in non-kinship placements		
mean	245	285
n	617	207
Percent of case spent in non-kinship placements		
mean	32%	41%
n	607	207

Table E4. Days to Permanent Placement

	SARMS	Drug Court
Days to permanent placement		
mean	292	258
n	460	138

Table E5. Permanency Outcomes

	SARMS	Drug Court
Percent of children reunified		
%	61%	32%
n	502	160
Percent of children with terminations of parental rights		
%	21%	39%
n	502	160
Percent of children with another permanency outcome		
%	18%	30%
n	502	160

Table E6. Child Welfare Recidivism

	SARMS	Drug Court
Percent subsequent petition on original case		
%	21%	25%
n	334	104
Percent with new substantiated cps referral since start of original case		
%	20%	27%
n	333	103
Percent with subsequent petition after the original case closed		
%	7%	17%
n	151	36
Percent with subsequent out-of-home placements after the original case closed		
%	7%	22%
n	151	36
Percent with subsequent terminations of parental rights after the original case closed		
%	1%	6%
n	143	33
Percent with a new drug-exposed baby (pregnant mothers only)		
%		
n	14%	33%
	49	21

Table E7. Contested Hearings & Court Order Compliance

	SARMS	Drug Court
Percent of cases with contested hearings		
%	29%	40%
n	312	99
Percent of cases with indications of noncompliance		
%	55%	87%
n	329	104

Table E8. Days to Court Case Closure

	SARMS	Drug Court
Days to court case closure		
mean	526	598
n	137	28

APPENDIX F: SITE-SPECIFIC ANCILLARY SERVICES DATA

Table F1. Service Need and Receipt—San Diego

Service	% needed during their case (*n*)	% received (*n*)
Help with transportation	64% (43)	51% (34)
Help with housing	51% (34)	21% (15)
Help getting health insurance	55% (37)	21% (14)
Help for children (e.g., counseling)	39% (26)	25% (16)
Parenting classes	73% (49)	69% (46)
Childcare	30% (20)	13% (9)
Help finding employment	27% (18)	13% (9)
Financial assistance	49% (33)	15% (10)
Mental health services	39% (26)	30% (20)
Substance abuse assessment	52% (35)	52% (35)
Substance abuse treatment services	72% (48)	69% (46)
Domestic violence services	25% (17)	17% (12)
Medical services/medication	39% (26)	28% (19)
Relationship or marital counseling	18% (12)	9% (6)

Table F2. Who Helped Provide the Services—San Diego

Service	Who helped obtain the service? % (*n*)						
	Drug Court Social Worker	Drug Court Judge	Attorney	CPS Caseworker	Treatment Provider	Other	No one
Help with transportation	9% (4)	2% (1)	0% (0)	42% (19)	9% (4)	33% (15)	4% (2)
Help with housing	17% (3)	6% (1)	6% (1)	6% (1)	11% (2)	33% (6)	22% (4)
Help getting health insurance	0% (0)	0% (0)	0% (0)	20% (3)	20% (3)	27% (4)	33% (5)
Help for children (e.g., counseling)	0% (0)	11% (2)	0% (0)	58% (11)	5% (1)	16% (3)	11% (2)
Parenting classes	25% (16)	2% (1)	2% (1)	25% (16)	22% (14)	16% (10)	8% (5)
Childcare	11% (1)	0% (0)	0% (0)	33% (3)	11% (1)	36% (4)	0% (0)
Help finding employment	0% (0)	0% (0)	0% (0)	0% (0)	33% (3)	56% (5)	11% (1)
Financial assistance	10% (1)	0% (0)	0% (0)	20% (2)	10% (1)	40% (4)	20% (2)
Mental health services	4% (1)	0% (0)	0% (0)	32% (8)	40% (10)	12% (3)	12% (3)
Substance abuse assessment	62% (28)	9% (4)	0% (0)	0% (0)	24% (11)	4% (2)	0% (0)
Substance abuse treatment services	48% (30)	6% (4)	0% (0)	8% (5)	24% (15)	10% (6)	3% (2)
Domestic violence services	0% (0)	22% (4)	6% (1)	44% (8)	6% (1)	17% (3)	6% (1)
Medical services/medication	0% (0)	0% (0)	0% (0)	0% (0)	21% (5)	54% (13)	25% (6)
Relationship or marital counseling	0% (0)	0% (0)	0% (0)	75% (6)	0% (0)	13% (1)	13% (1)

Table F3. Service Need and Receipt—Santa Clara

Service	% needed during their case (*n*)	% received (*n*)
Help with transportation	93% (26)	89% (25)
Help with housing	79% (22)	50% (14)
Help getting health insurance	64% (18)	25% (7)
Help for children (e.g., counseling)	68% (19)	61% (17)
Parenting classes	93% (26)	93% (26)
Childcare	43% (12)	32% (9)
Help finding employment	36% (10)	19% (6)
Financial assistance	86% (24)	64% (18)
Mental health services	46% (13)	39% (11)
Substance abuse assessment	36% (10)	32% (9)
Substance abuse treatment services	93% (26)	93% (26)
Domestic violence services	36% (10)	32% (9)
Medical services/medication	50% (14)	36% (10)
Relationship or marital counseling	25% (7)	7% (2)

Table F4. Who Helped Provide the Services—Santa Clara

Service	Who helped obtain the service? % (*n*)						
	Drug Court Social Worker	Drug Court Judge	Attorney	CPS Caseworker	Treatment Provider	Other	No one
Help with transportation	18% (7)	16% (6)	0% (0)	47% (18)	3% (1)	16% (6)	0% (0)
Help with housing	10% (2)	14% (3)	5% (1)	24% (5)	24% (5)	19% (4)	5% (1)
Help getting health insurance	11% (1)	0% (0)	0% (0)	22% (2)	11% (1)	44% (4)	11% (1)
Help for children (e.g., counseling)	13% (3)	0% (0)	9% (2)	39% (9)	0% (0)	31% (7)	9% (2)
Parenting classes	17% (6)	25% (9)	0% (0)	47% (17)	6% (2)	6% (2)	0% (0)
Childcare	0% (0)	0% (0)	0% (0)	5% (5)	0% (0)	40% (4)	10% (1)
Help finding employment	0% (0)	0% (0)	0% (0)	0% (0)	14% (1)	43% (3)	43% (3)
Financial assistance	0% (0)	0% (0)	0% (0)	26% (6)	9% (2)	39% (9)	17% (4)
Mental health services	8% (1)	8% (1)	0% (0)	58% (7)	8% (1)	17% (2)	0% (0)
Substance abuse assessment	0% (0)	18% (2)	0% (0)	27% (3)	55% (6)	0% (0)	0% (0)
Substance abuse treatment services	14% (7)	18% (9)	2% (1)	26% (13)	20% (10)	12% (6)	10% (5)
Domestic violence services	19% (3)	25% (4)	0% (0)	31% (5)	6% (1)	13% (2)	6% (1)
Medical services / medication	0% (0)	8% (1)	8% (1)	8% (1)	8% (1)	15% (2)	54% (7)
Relationship or marital counseling	50% (2)	0% (0)	0% (0)	0% (0)	50% (2)	0% (0)	0% (0)

Table F5. Service Need and Receipt—Suffolk

Service	% needed during their case (*n*)	% received (*n*)
Help with transportation	50% (12)	33% (8)
Help with housing	29% (7)	13% (3)
Help getting health insurance	25% (6)	13% (3)
Help for children (e.g., counseling)	42% (10)	42% (10)
Parenting classes	54% (13)	42% (10)
Childcare	29% (7)	25% (6)
Help finding employment	13% (3)	4% (1)
Financial assistance	50% (12)	17% (4)
Mental health services	29% (7)	25% (6)
Substance abuse assessment	46% (11)	46% (11)
Substance abuse treatment services	50% (12)	46% (11)
Domestic violence services	17% (4)	8% (2)
Medical services/medication	63% (15)	54% (13)
Relationship or marital counseling	13% (3)	13% (3)

Table F6. Who Helped Provide the Services—Suffolk

Service	Who helped obtain the service? % (*n*)						
	Drug Court Social Worker	Drug Court Judge	Attorney	CPS Caseworker	Treatment Provider	Other	No one
Help with transportation	20% (2)	10% (1)	0% (0)	0% (0)	20% (2)	50% (5)	0% (0)
Help with housing	0% (0)	0% (0)	0% (0)	0% (0)	33% (1)	33% (1)	33% (1)
Help getting health insurance	0% (0)	0% (0)	0% (0)	33% (1)	0% (0)	33% (1)	33% (1)
Help for children (e.g., counseling)	18% (2)	9% (1)	0% (0)	9% (1)	9% (1)	27% (3)	27% (3)
Parenting classes	50% (5)	10% (1)	0% (0)	10% (1)	20% (2)	10% (1)	0% (0)
Childcare	14% (1)	0% (0)	0% (0)	43% (3)	0% (0)	29% (2)	14% (1)
Help finding employment	100% (1)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Financial assistance	0% (0)	0% (0)	14% (1)	14% (1)	0% (0)	29% (2)	43% (3)
Mental health services	0% (0)	0% (0)	0% (0)	14% (1)	71% (5)	14% (1)	0% (0)
Substance abuse assessment	8% (1)	23% (3)	0% (0)	15% (2)	31% (4)	15% (2)	8% (1)
Substance abuse treatment services	35% (6)	6% (1)	0% (0)	6% (1)	24% (4)	12% (2)	18% (3)
Domestic violence services	100% (2)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Medical services / medication	6% (1)	0% (0)	0% (0)	6% (1)	50% (8)	6% (1)	39% (5)
Relationship or marital counseling	40% (2)	0% (0)	0% (0)	0% (0)	20% (1)	20% (1)	20% (1)

Table F7. Service Need and Receipt—Washoe

Service	% needed during their case (*n*)	% received (*n*)
Help with transportation	69% (11)	63% (10)
Help with housing	69% (11)	63% (10)
Help getting health insurance	56% (9)	32% (5)
Help for children (e.g., counseling)	88% (14)	81% (13)
Parenting classes	81% (13)	75% (12)
Childcare	38% (6)	38% (6)
Help finding employment	25% (4)	13% (2)
Financial assistance	69% (11)	50% (8)
Mental health services	38% (6)	25% (4)
Substance abuse assessment	44% (7)	44% (7)
Substance abuse treatment services	100% (16)	100% (16)
Domestic violence services	25% (4)	19% (3)
Medical services/medication	63% (10)	63% (10)
Relationship or marital counseling	50% (8)	25% (4)

Table F8. Who Helped Provide the Services—Washoe

Service	Who helped obtain the service? % (*n*)						
	Drug Court Social Worker	Drug Court Judge	Attorney	CPS Caseworker	Treatment Provider	Other	No one
Help with transportation	0%	7%	0%	50%	21%	21%	0%
	(0)	(1)	(0)	(7)	(3)	(3)	(0)
Help with housing	0%	0%	0%	25%	42%	17%	17%
	(0)	(0)	(0)	(3)	(5)	(2)	(2)
Help getting health insurance	0%	0%	0%	20%	40%	20%	20%
	(0)	(0)	(0)	(1)	(2)	(1)	(1)
Help for children (e.g., counseling)	0%	11%	6%	56%	11%	6%	6%
	(0)	(2)	(1)	(10)	(2)	(1)	(1)
Parenting classes	0%	7%	0%	19%	69%	6%	0%
	(0)	(1)	(0)	(3)	(11)	(1)	(0)
Childcare	0%	17%	0%	17%	17%	33%	17%
	(0)	(1)	(0)	(1)	(1)	(2)	(1)
Help finding employment	0%	50%	0%	0%	50%	0%	0%
	(0)	(1)	(0)	(0)	(1)	(0)	(0)
Financial assistance	0%	13%	0%	13%	38%	25%	38%
	(0)	(1)	(0)	(1)	(3)	(2)	(3)
Mental health services	0%	0%	0%	40%	20%	20%	20%
	(0)	(0)	(0)	(2)	(1)	(1)	(1)
Substance abuse assessment	0%	25%	0%	63%	13%	0%	0%
	(0)	(2)	(0)	(5)	(1)	(0)	(0)
Substance abuse treatment services	0%	24%	0%	42%	33%	0%	0%
	(0)	(8)	(0)	(14)	(11)	(0)	(0)
Domestic violence services	0%	25%	0%	75%	0%	0%	0%
	(0)	(1)	(0)	(3)	(0)	(0)	(0)
Medical services / medication	0%	7%	7%	7%	20%	33%	27%
	(0)	(1)	(1)	(1)	(3)	(5)	(4)
Relationship or marital counseling	0%	25%	0%	0%	25%	25%	25%
	(0)	(1)	(0)	(0)	(1)	(1)	(1)

APPENDIX G: STATISTICAL DETAIL

Statistical Detail

For all tables, F-values are marked as follows:
*p<.05
**p<.01
***p<.001

Table G1. Administrative Data Sample: Effects of FTDC Experiences on Likelihood of Entering Treatment

		N	F	R change	b
Time from petition to DC (no SU)		273	chisq=0.05	0	0.001
Total days in DC		---	---	---	---
Total DC appearances		---	---	---	---
DC Grad Status	Term vs. else	---	---	---	---

Table G2. Administrative Data Sample: Effects of FTDC Experiences on Time to Enter Treatment

		Time to Tx			
		N	F	R change	b
Time from petition to DC (no SU)		186	10.46***	0.05	0.28
Total days in DC		---	---	---	---
Total DC appearances		---	---	---	---
DC Grad Status	Term vs. else	---	----	----	----

Table G3. Administrative Data Sample: Effects of FTDC Experiences on Days Spent in Treatment

		Days in Tx			
		N	F	R change	b
Time from petition to DC (no SU)		272	1.33	0.01	0.15
Total days in DC		310	30.15***	0.09	0.57
Total DC appearances		335	23.75***	0.06	6.41
DC Grad Status	Term vs. else	388	3.32	0.02	1.82

Table G4. Administrative Data Sample: Effects of FTDC Experiences on Likelihood of Completing Treatment

		Treatment Completion			
		N	F	R change	b
Time from petition to DC (no SU)		224	chisq=0.24	0.002	-0.001
Total days in DC		263	chisq=22.65***	0.09	0.01
Total DC appearances		280	chisq=15.07***	0.06	0.06
DC Grad Status	Term vs. else	321	chisq=16.01***	0.06	0.61

Table G5. Administrative Sample: Effects of FTDC Experiences on Likelihood of Reunification

	N	F	b
Time from petition to DC (no SU)	477	0.001	< . 001
Total days in DC	516	43.41***	0.001
Total DC appearances	517	23.29***	0.02
DC Grad Status (No vs. else)	554	17.24	-0.41

Table G6. Administrative Data Sample: Treatment Experiences as Predictors of Time in Treatment

	Days in Tx			
	N	F	R change	b
Time to Tx	271	26.67***	0.09	-0.55
Time in Tx	---	---	---	---

Table G7. Administrative Data Sample: Treatment Experiences as Predictors of Likelihood of Treatment Completion

	Treatment Completion			
	N	F	R change	b
Time to Tx	214	chisq=9.74**	0.05	-0.01
Time in Treatment	328	chisq=197*.75**	0.51	0.01

Table G8. Administrative Sample: Effects of Treatment Experiences on Likelihood of Reunification

	N	F	b
Tx entry	571	0.0001	0.0002
Time to Tx	400	1.65	-0.0004
Time spent in tx	571	2.21	0.0002
Tx completion	469	17.32***	0.23

Table G9. Interview Sample: Treatment Experiences as Predictors of the Number of Days Spent in Treatment

	Days in Tx			
	N	F	R change	b
Tx access/appropriateness (B+6)	126	3.29, p < .08	0.02	79.96
Frequency of UAs (B+6)	129	6.2*	0.04	52.37
Frequency of meeting with Tx (B+6)	129	6.15*	0.04	45.85
Quality of relationship w/Tx (B+6)	126	0.75	0.01	34.79

Table G10. Interview Sample: Treatment Experiences as Predictors of the Likelihood of Completing at Least One Treatment Episode

	Treatment Completion			
	N	chisq	R change	b
Tx access/appropriateness (B+6)	99	2.78	0.03	0.92
Frequency of UAs (B+6)	102	13.35***	0.17	0.95
Frequency of meeting with Tx (B+6)	102	4.07*	0.04	0.46
Quality of relationship w/Tx (B+6)	95	9.55**	0.09	1.92

Table G11. Interview Sample: Treatment Experiences as Predictors of the Likelihood of Reunification

	N	F	b
Tx access/appropriateness (B+6)	174	4.28*	0.22
Frequency of UAs (B+6)	178	3.64, p < .06	0.09
Frequency of meeting with Tx (B+6)	177	6.87*	0.12
Quality of relationship w/Tx (B+6)	166	0.001	0.003

Table G12. Administrative Sample: Effects of Parent Characteristics on Time to Drug Court

	N	F
Site	279	41.17***
Race	274	0.04
Demographic Risk	279	0.01
Age of 1st drug use	279	1.03
Parent Age	279	3.18
Child Risk	278	0.23
MH history (0=no, 1=yes)	279	2.4
CW history	279	1.31
At least 1 infant	279	0.79
At least 1 toddler (0=no, 1=yes)	279	3.12
At least 1 older child	279	0.21
Meth use (no Suffolk)	217	0.3

Table G13. Administrative Sample: Effects of Parent Characteristics on Days in Drug Court

	N	F
Site	315	47.5***
Race	312	1.8
Demographic Risk	315	0.5
Age of 1st drug use	315	0.55
Parent Age	315	3.5, p < .06
Child Risk	314	0.53
MH history (0=no, 1=yes)	315	2.94
CW history	315	2.54
At least 1 infant	315	0.07
At least 1 toddler (0=no, 1=yes)	315	1.51
At least 1 older child	315	2.77
Meth use (no Suffolk)	193	0.22

Table G14. Effects of Parent Characteristics on Number of FTDC Appearances

	N	F
Site	342	56.03***
Race	338	3.83*
Demographic Risk	342	8.39*
Age of 1st drug use	342	2.49
Parent Age	342	9.41**
Child Risk	341	4.0*
MH history (0=no, 1=yes)	341	2.51
CW history	342	0.19
At least 1 infant	342	1.23
At least 1 toddler (0=no, 1=yes)	342	0.05
At least 1 older child	342	2.94
Meth use (no Suffolk)	198	0.25

Table G15. Effects of Parent Characteristics on Probability of FTDC Graduation

	N	Chisq
Site		
Race	322	13.41***
Demographic Risk	326	2.52
Age of 1st drug use	326	0.03
Parent Age	326	0.52
Child Risk	325	0.06
MH history (0=no, 1=yes)	326	0.56
CW history	326	8.11**
At least 1 infant	326	3.09
At least 1 toddler (0=no, 1=yes)	326	2.55
At least 1 older child	326	0.63
Meth use (no Suffolk)	202	0.00001

Table G16. Administrative Data Sample: Effects of Parent Characteristics on Likelihood of Entering Treatment

	N	Chisq
Site	405	8.28*
Race	399	3.64
Demographic Risk	405	5.42*
Education (0=less than HS, 1=HS+)	405	7.46*
Employment	405	0.22
Married (0=unmarried, 1 =married)	405	4.70*
Age of 1st drug use	405	0.63
Parent Age	405	1.89
Child Risk	404	0.02
MH history (0=no, 1=yes)	402	1.22
CW history	405	1.28
At least 1 infant	405	1.3
At least 1 toddler (0=no, 1=yes)	405	1.1
At least 1 older child	405	0.01
Meth use (no Suffolk)	222	1.68

Table G17. Administrative Data Sample: Effects of Parent Characteristics on Time to Enter Treatment

	N	F
Site	279	2.23
Race	275	0.49
Demographic Risk	279	0.08
Education (0=less than HS, 1=HS+)	279	0.61
Employment	279	0.66
Married (0=unmarried, 1 =married)	279	0.73
Age of 1st drug use	279	1.44
Parent Age	279	1.6
Child Risk	278	0.01
MH history (0=no, 1=yes)	277	1.19
CW history	279	0.4
At least 1 infant	279	0.7
At least 1 toddler (0=no, 1=yes)	279	< 0.01
At least 1 older child	279	0.06
Meth use (no Suffolk)	197	0.02

Table G18. Administrative Data Sample: Effects of Parent Characteristics on Days Spent in Treatment

	N	F
Site	405	2.87*
Race	399	1.65
Demographic Risk	405	3.04
Education (0=less than HS, 1=HS+)	405	6.08*
Employment	405	0.32
Married (0=unmarried, 1 =married)	405	0.71
Age of 1st drug use	405	4.28*
Parent Age	405	1.83
Child Risk	404	0.02
MH history (0=no, 1=yes)	402	9.36**
CW history	405	1.39
At least 1 infant	405	2.39
At least 1 toddler (0=no, 1=yes)	405	4.25*
At least 1 older child	405	0.32
Meth use (no Suffolk)	222	0.01

Table G19. Administrative Data Sample: Effects of Parent Characteristics on Likelihood of Completing Treatment

	N	Chisq
Site	336	28.8***
Race	330	1.87
Demographic Risk	336	9.07**
Education (0=less than HS, 1=HS+)	336	10.97**
Employment	336	0.002
Married (0=unmarried, 1 =married)	336	0.37
Age of 1st drug use	336	0.03
Parent Age	336	2.76
Child Risk	335	2.55
MH history (0=no, 1=yes)	335	3.48
CW history	336	0.97
At least 1 infant	336	2.63
At least 1 toddler (0=no, 1=yes)	336	1.54
At least 1 older child	336	0.44
Meth use (no Suffolk)	172	0.07

Table G20. Administrative Data: Effects of Parent Characteristics on Likelihood of Reunification

	N	F	b
Site	574	32.01***	---
Race	572	2.37, p < .08	---
Demographic Risk	574	5.08*	-0.08
Age of 1st drug use	574	0.03	0.001
Parent Age	574	0.66	-0.003
Child Risk	573	1.32	-0.03
MH history	574	0.04	---
CW history	574	4.63*	---
At least 1 infant	574	0.3	---
At least 1 toddler	574	3.50, p < .07	---
At least 1 older child	574	0.7	---
Meth use (no Suffolk)	384	0.01	---